Moral Issues and Motivations in Medical Philanthropy

by

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Abstract

This ethnographic study of fifteen physicians, ten medical students and ten pre-medical students focuses on the self-reported motivations of these individuals for engaging in medically-related charitable or philanthropic activity, and the moral issues arising from such activity. The study is based on information gleaned from personal, structured interviews with each of the subjects ranging in length from approximately 25 minutes to one-and-a-half hours. The subjects themselves were selected and recruited based on the perceptions of key informants that they were persons who had demonstrated interest in and commitment to charitable medical work.

We discovered that the primary influences motivating entry into the medical profession were parental example and positive experiences with a physician in childhood or youth. Many of our subjects also reported an aptitude for science and a desire to help people. When asked specifically about motivations to engage in philanthropic medical activity, upbringing and the sense of obligation stood out as most prominent. Many respondents reported that they came from families where volunteering played an integral part. Many also reported a sense of obligation, or a desire to give back, based on an awareness of privilege and the possession of the requisite skills. In some cases, religious teaching was also specifically mentioned. Other motivations included the intrinsic enjoyment of helping others and the interest and fulfillment that volunteer activities provide. A desire to help redress the current maldistribution of health care resources was also mentioned by several, as was the good feeling that comes from knowing that one is making a difference to others, and their expressed appreciation. Finally, for the medical and pre-medical student, volunteer medical activity provides learning experiences that enhance one’s sense of professional identity and purpose, while also enlarging one’s abilities and strengthening one’s resume.

The great majority of those interviewed regarded their motivations for engaging in medically-related philanthropic activity as primarily moral, though a number also thought of them as religious and a somewhat lesser number thought of them as political. In a few instances, the religious or the political seemed more decisive or determinative than the moral. The most frequently identified issue emerging from the volunteer and philanthropic involvements of these physicians and physicians-in-training was that of limited and unequal access to health care resources due to the current state of maldistribution of those resources. The lack of universal health care insurance or some alternative means of insuring access was seen as problematic by virtually every respondent. Disparities between first-world and third-world health care systems and resources were also noted, especially by the medical and pre-medical students. Several interviewees expressed reservations about the effectiveness of some forms of medical philanthropy, especially where continuity of care is lacking. In general, there was recognition of the need for systemic changes in the way health care is provided here and abroad, though this was often not well articulated.

Another set of issues emerged that are identified in this report as relational issues. Some relational issues focus on family and peers, and are discussed under the section on “Personal Costs” below. Other relational issues arise from the fact that physicians, especially those engaged in philanthropic activity, must relate to all kinds of people who are their patients, patient family members, colleagues, and institutional counterparts, across social, racial, economic,
cultural, national, and geographic divides. There is also discussion in the report regarding the values of group practice as a means of providing cost-effective medical care precisely in order to allow physicians some freedom and discretion regarding the utilization of their time and gifts to engage in medically-related philanthropic activity.

This report devotes considerable attention to the question of what defines “medical philanthropy.” Although no precise definition is offered, the argument is made that it is not sufficient to define it as 1) free, 2) unremunerated, 3) volunteer, 4) medical care. Some of the activities discussed below, which are considered to be rightfully regarded as forms of medical philanthropy, would fail to qualify on one or more of the above terms. Moreover, some activities that meet as many as three of these four criteria are not regarded as necessarily medically philanthropic. This report gestures toward a definition of medical philanthropy that relies upon notions of equitableness and social justice as criteria for designating the morally obligatory and distinguishing it from the morally supererogatory. Only the latter is seen as charitable or philanthropic.

One additional important theme that emerged from the interviews and is reported here has to do with the importance of medically-related philanthropic experience to the educational, professional, and vocational choices of the pre-medical and medical students and to their subsequent philanthropic commitments and activities as well as those of the physicians in our study. Key to the encouragement of medical philanthropy may be the more integral incorporation of medically-related philanthropic activities in the pre-medical and medical school curriculum. Some of our respondents’ comments and observations suggest that greater opportunity and support for philanthropic work in medical school education, in particular, would not only encourage subsequent medical philanthropy but would also be of significant pedagogical benefit.
INTRODUCTION

Why do individuals enter the field of medicine? What are some of the more significant motivating factors, events, or experiences? Why, in particular, do physicians, and physicians-in-training, engage in volunteer or charitable medical-related activity? What moral, religious, or other values and impulses appear to prompt such philanthropic medical activity? What are some of the important moral issues that arise from participation in such activity? What are the meanings attached to such activity? How does participation in volunteer medical-related activity appear to affect those involved?

These are the sorts of questions that this study has sought to explore. The data for this study were gathered by means of semi-structured interviews. We began with the goal to interview 15 physicians, 10 medical students, and 10 pre-medical students, all of whom were judged to have participated in some significant volunteer medical activity. In most if not all cases, these were individuals who were regarded as possessing some commitment to medical philanthropy. In the course of our interviews, we discovered that what might be considered philanthropic by some would not be considered philanthropic by all. Not all of the individuals we interviewed considered themselves to be engaged in philanthropic medical work. However, to us and/or to those by whom we were informed, these were persons who were thought to be appropriate subjects for our study. Moreover, the activity of some persons who understood themselves to be engaged in philanthropic work is not of the sort that all of their colleagues would deem philanthropic. Thus, the question of what constitutes medical philanthropy is one of the major issues to be discussed below.

A brief account of the methodology of the study is provided in Appendix A. Here I will supply only a summary sketch of the demographics of the participants in the study. The cohort of pre-medical students in the study was comprised of four juniors and six seniors, all from Indiana University. Eight of them were science majors, primarily in biology or biochemistry, while one was majoring in a humanities field and another in one of the social sciences. Several were also studying Spanish, either as a major or a minor field. This interest in Spanish may correlate with the fact that the major overseas opportunities for volunteer medical-related activity available to Indiana University undergraduate students are in the Dominican Republic and Honduras. The Bloomington campus has a local undergraduate chapter of the Indianapolis-based Timmy Foundation, which promotes and sponsors a medical mission trip to each of these locations every year over spring break. Seven of the ten pre-med students interviewed had been on at least one of these mission trips. For three or four of these students, the Timmy Foundation experience has been their only significant involvement in medically-related philanthropy.

The cohort of medical students in the study was comprised of one 1st-year student, five 2nd-year students, and four 4th-year students. Eight of these were attending Indiana University Medical School, and two were from the University of Texas Medical Branch, Galveston, Texas. Again, although most had undergraduate majors in biology, biochemistry, or chemistry, other majors
included applied mathematics, communication studies, nutrition, religious studies, and Russian. These ten medical students were graduates of eight different undergraduate institutions.

The physicians in our study represent a wide range of backgrounds and experience. Data on their undergraduate majors is incomplete. However, in terms of their educational backgrounds, they represent at least ten different undergraduate institutions and at least nine different medical schools. The pre-med and medical school student cohorts were both comprised of seven women and three men. Among the physicians, there were four women and eleven men. No effort was made in this study to select participants on the basis of gender. With respect to the undergraduates, however, we found it was easier to secure consent to participate in the study among the female pre-med students than their male counterparts.

It will be evident from these comments that the data of our study do not provide much basis for quantitative analysis. However, the interviews provide a rich basis for qualitative analysis that is informative, illuminating, and provocative. The method of the study is biographic and ethnographic. The transcripts of our interviews each tell a story. That story is not simply a recounting of dates, times, and places, but an interpretation of events, layered with meanings, that the teller associates with his or her individual purposes and chosen profession. Each story contains narratives that help to organize the individual’s personal experiences and commitments. A major goal of our analysis is to identify those features of each narrative that emerge as significant in terms of the meaning and structure they give to the narrative, either because of their place in the story, or because they are shared by others, or perhaps because they are distinctive in some way.

For example, it is evident in many of our interviews that an experience of overseas medical service, such as a medical mission trip, has played an important role in the professional development and vocational orientation of those individuals who have had such an experience. A number of participants spoke of such an experience as “eye-opening.” A number clearly found their professional, moral, or political sensibilities challenged and changed by such an experience. Within any particular narrative, such an experience may have significance for an individual’s personal vocational direction. The fact that such experiences are common to a number of participants suggests, more generally, that they may be of particular importance in engendering professional or moral commitments to medical philanthropy. But it is also apparent in some cases that such an experience exercised its own unique and distinctive influence in the life of the individual in ways, or to an extent, not commonly shared. In the analysis that follows I seek to identify and interpret some of the more significant features of the various stories we have heard, particularly with respect to the motivations that prompt and sustain medically-related philanthropic activity and the moral issues that emerge from engagement in such activity.

On the one hand, therefore, we are seeking a rich and nuanced understanding of why individuals engage in charitable medical work. We hope to discover what makes such work fulfilling, how others
might be encouraged to participate in it, and how those who do engage in it may be sustained in their efforts. On the other hand, we also want to examine the actual implications of such activity, including the moral meanings attached to it, and any moral dilemmas or challenges that it presents. In so doing, we will be engaged in a double critique. In the first place, philanthropic medical activity brings to the practice of medicine a perspective, or variety of perspectives, from which to question and assess the prevailing, nonphilanthropic practice of medicine. Most philanthropic medical activity is undertaken to address medical needs that would otherwise go unmet. But in the second place, there are inherent limitations to philanthropic medical activity in terms of what can be accomplished and what can be sustained, and also in terms of the kinds of relationships that typically characterize charitable medical practice. These limitations occasion an internal critique. To anticipate one of the conclusions of the analysis to follow, charitable medical work is often a mixed blessing. It can and does play an important role in providing health care to so-called underserved populations. However, at least a few of the participants in our study seemed to suggest that it sometimes makes little difference and may even do more harm than good.

That said, it also needs to be said that many of the stories on which the following report is based are truly remarkable and inspiring. The generosity, commitment, and sacrifice of many of the participants in this study, and the magnitude of service and accomplishment of more than a few, are truly humbling. Unfortunately, to relate these stories in sufficient detail so as fully to commensurate their inspiring qualities would surely deprive some of the participants in this study of their anonymity. Consequently, a certain vagueness or lack of specificity must attend the descriptions of some of the philanthropic activities reported on here. Nonetheless, recognizing the virtues of clarity and economy of expression, and observing the limits imposed by the need to preserve anonymity, I will try to let our participants speak in their own words as much as possible. It will help the reader to know that italicized names and places in the excerpts below have been fabricated so as not to provide unnecessary clues to the identity of our subjects.

WHY THE PRACTICE OF MEDICINE?

The first question we asked in our interviews had to do with the factors, influences, and events that led our participants to enter the field of medicine as a profession. One native Indiana physician responded, “My father was a doctor, I grew up with medicine and never considered doing anything else except being a basketball coach, and that came in second.”

Another respondent reported:

Well, you knew most people have, like, parents who are physicians. I don’t have any doctors in my family at all. I actually grew up about ten minutes away from the medical center, and when I was growing up I remember my parents and everybody thinking the medical center was just the greatest thing on earth. And I had asthma as a child and really just loved the allergist that took care of me, and he would always say, “Well, you’re going to grow up and you’re going to take my job.” And so it was just one of those things that at a very young age I kind of focused on, and then, that’s just kind of what it was going to be forever. There really wasn’t any other thing that made it change.
These two responses capture two of the most prominent themes in answer to our first question. On the one hand, a least seven of those we interviewed, including four of the undergraduates, had fathers who were doctors. Another reported that many of his parents’ friends were physicians. One had a father who was a dentist, another’s father was pharmacist, and two others reported that their mother were nurses. It is clear that for most of these, the parent was a positive role model. As one pre-med student put it, “Since I was very little, that’s always what I wanted to be, just watching my dad and that kind of thing.” As one of the medical students explained, “I had a good example growing up. My father’s a physician, so I sort of saw what it was like for him and, yeah, saw the good and the bad, but I always really respected—still respect—what he does, and so I guess there was that sort of example all along. . . .”

Along with having a parent who is in medicine comes a familiarity with the medical field, mentioned by a couple of students. Additional dimensions of medical practice are reflected in the following response:

My dad’s a doctor, so I kind of have been around, I guess, a physician lifestyle. And being in a small town, it’s very much more personal, I think, than a lot of other places, so his patients would stop by the house, and I’ve met a lot of them, and it’s just been something that— I see it as an opportunity to get to know a lot of people and form relationships.

The theme of relationships is one that recurs in our interviews, in a variety of different ways. Most of the participants in our study are aware that, for them, the practice of medicine is attractive in large part because of the relationships it affords them. These relationships include those between physician and patient, or between physician and the patient’s family, but they also include relationships within other communities, including communities of residence, professional communities, and various institutional communities.

For a significant number of our participants, the decision to enter the field of medicine was influenced by a positive parental role model. But this appears to be the case for only about one-third of those in our study. What about the rest? A surprising number of respondents who reported no family connections with the medical profession nonetheless indicated that there had been a physician in their childhood or youth who was important as a positive influence or role model in the decision to pursue a medical vocation. As we have already seen, in one case it was an allergist toward whom the young patient and future physician felt a great affection. Another respondent whose father was a physician also found in his neighbor a potent role model:

[My father was a physician. He was actually a pathologist . . . and . . . as a child my next door neighbor was the family doctor in town. And I think that always, I appreciated how, as a kid going in to see him when I had to get a shot or whatsoever, I always appreciated his demeanor, the way he treated me, and just, I think, in general the way he treated people.

The positive experience of treatment by a physician was, in fact, mentioned by several participants. One described the main influence in choosing a career in medicine as follows:

[All through high school I played competitive tennis, and I had a couple of things go wrong with my feet, and so I ended up having surgery on one of them before my senior year. So I spent a lot of time in the doctor’s office, and they let me come back and chat a little, so that got me hooked on it. So I’d kind of been
Another participant cited an even more specific set of experiences that apparently made all the difference in her vocational choice:

Well, first of all, when I was 16 years old I was a cheerleader, and ultimately ended up needing three knee surgeries in about a six month period. So that's when I was first really introduced to the medical field. At that point in time I thought I wanted to do physical therapy, just because I saw so much of the rehab, so it wasn't until later, after that experience, until I had actually entered college, that I decided that I did indeed want to do more of the diagnostic aspect of things and become a physician. But at that point I was working for the orthopedic surgeon who actually did my knee surgery, because he was in University City and I'm originally from Tarrytown, so when he found out I was coming to ABC University, he said, "Do you want to work a couple days a week for me if you can get around your schedule?" and I said, "Yeah." And so I did that for four years, so I guess that was my initial interest, and everything just seemed to work out from that point on.

As these excerpts from our transcripts indicate, significant and positive exposure to the medical profession can serve as a decisive factor in the decision to pursue a medical career. Even experiences that may not seem quite so obviously influential may make a difference, however. As one respondent explained, "I had a grandmother who had all the complications you could have with diabetes, and ultimately died of breast cancer, and because of Grandma I thought I wanted to do something to help people." Another reported:

My mother tells me that she had migraine headaches and sometimes she would wake up in the morning with migraine headaches and she said I would go to her and say, "When I grow up I'm going to be a doctor and fix your migraine headaches." I don't know if that's true or not, but that's the story I got.

Yet another gave the following amusing and somewhat ironic account:

I was about ten years of age and I developed a sore throat. My father took me to an old country physician, a fine old gentleman—privileged to take care of his grandchildren—whom gave me a shot. He drew up an old barrel and puffer out of a tray with his fingers, took a needle out of a little boat—that needle filled it on a little stone—I drew up an injection of medicine, and gave it to me. And it hurt. I cried and yelped and went out of that office. Said, "Dad, I'm going to be a doctor, and I won't give shots!"

It may be obvious, but it bears noting, that most children and young people have some personal experience with a physician or other members of the medical profession during their growing-up years. The same probably cannot be said with regard to most other professions. In any event, many of the participants in our study found those early experiences to be especially meaningful and influential in their subsequent decisions to pursue medical training. In some cases, such an experience was the only identified factor in an individual's decision to become a physician. In other cases, such an experience helped to confirm what was already entertained as a possibility. In yet other cases, such an experience provided an opening to further exploration, including employment within a medical context, that eventuated in a choice of medical career.

For at least a few of the participants in our study there has been a significant relationship between actual employment experience within a medical setting and the decision to pursue a medical career. One respondent mentioned a meaningful experience in high school as a counselor for a summer camp for physically and mentally handicapped children. Another spoke of taking a job as a surgical assistant in a hospital while in the course of pursuing a
music career after college, where "one thing kind of led to another," such that he ended up returning to school in pursuit of a medical education. Two respondents, both of whom had clear plans of becoming a doctor, spoke at greater length of the importance their work experiences played in shaping and confirming their vocational decisions. The first of these, the first in her family to go to college, had long thought she would go into medicine. "I was one of those people that just knew from the time that I was little. I mean, my parents always said that from the time that I could walk and talk I've always said that I wanted to be a doctor." She goes on to report:

Well, as a child growing up I always said that I was going to be a doctor. When I grew up, and in keeping with that, I held some jobs along the way that sort of reinforced that. Probably the single most influential, I worked as an E.R. technician in my home town hospital and, really, I think that was sort of my litmus test of whether or not . . . this was really, really what I wanted to do. I actually started that position, I believe I was a sophomore in college, maybe the summer between my first and second year of college, and worked there for really up until the time that I started med school. So, that was probably the biggest, you know, related field, medically speaking, that I was paid for . . . I also worked as a hospice volunteer when I was in college, and that was also kind of—I said, "Okay I can handle all of the things in a hospital setting and caring for patients and caring for you, know, all of their emotions and everything that comes with caring for patients"—but, you know, one of the things that I was always kind of worried about was whether or not I would be able to, how I would deal with death, knowing that I would be facing that in my future career. So I worked as a hospice volunteer and loved that it, too, so I guess—and that was, I did that my junior and senior year of college—so those were, I guess, kind of reinforcing factors . . . that I really was sure that medicine was for me. And then I entered med school.

This account is exceptional in the extent to which it reflects a very deliberate, conscious attempt to confirm a vocational choice. It is interesting to reflect upon the fact that it comes from someone who had little basis in family history or personal experience for making a vocational decision of this sort, but it is impossible to say to what extent personal background and experience account for such a conscientious approach.

The other account comes from someone who made a decision in high school to become a doctor, and had some contact with, and exposure to, physicians during the high school years:

[At that time] I guess I wasn't very knowledgeable in all the areas of medicine, and so I just assumed that there were only two kinds of doctors. I thought there were family doctors and I thought there were surgeons and so I didn't know which of those two I would want to become some day, but you know other one would have been fine. And so then when I graduated from high school I got a job in the local operating room in the small town hospital . . . in the town that I grew up in. And at the hospital they allowed me to start off as a—, they called it—my official job title was O.R. aide, which was sort of a glorified term for the person who did all the little things that no one really else wants to do. So I washed and sterilized surgical instruments after the cases. I pulled all the instruments for the cases. I would map the floors in-between the cases. But the longer I worked there the more experiences they offered me, so I went and they would let me see patients before surgery, let me try to start IVs. They would allow me to move patients after surgery up to the floors. They would let me see people in the E.R. with the other physicians, and by the time I got to the end of the first summer they actually would let me scrub in and assist with the cases, and again, I didn't always know exactly what was going on, but you know I would sometimes just stand and watch and sometimes I would get to—and this is sort of again, this is sort of a glorified med student job, although if the time I was just a, had just graduated from high school—but they allowed me to what we call retract, or if someone has made an incision, they allow you to hold onto an instrument that tries to pull some of those things out of the way, which again is, it's so
hard to mess up that anybody could probably do it. So they let me do that, and as time went on they gave me more and more responsibilities in patient care and more and more responsibilities in surgery, and when I ended up, you know, finishing, you know, college I had applied to medical school, I had gotten into ATSU, and when I finished that experience of working in the operating room I knew that I either wanted to become a general surgeon or an orthopedic surgeon. And when I went through medical school I much sooner gravitated toward general surgery, as opposed to orthopedic surgery, and on top of, I guess to sum all that up, then, because I started in a small town, I’ve always loved small towns, and so my goal ... was actually to go back to a small town and practice small-town general surgery.

These two longer excerpts from our interviews suggest something of the possible interplay between work experience and vocational decision. Other evidence of such interplay came from respondents who indicated that they had been candy stripers or had volunteered in other ways in hospital settings, beginning in middle school or early high school years. In most cases our interviews did not reveal significant evidence of such interplay, however. On the other hand, a four-month stint in an overseas medical hospital helped convince one medical student that he did not wish to become a medical missionary. When it comes specifically to engagement in charitable medical work, our interviews reveal that the interplay between particular work experiences and commitment to philanthropic medical activity is often very significant, rich, and complex.

The second of the two major excerpts just reported implicitly raises another issue, of a distinctively moral nature, to which we will subsequently return. Simply put, this is the question of qualifications for the practice of medicine. Here we have an instance of active participation in surgical procedures by someone without formal, credentials.

medical training, in small-town America. As we will see, the same question arises to some extent in third world settings, where pre-med and medical students are given the freedom to participate in medical care practices to an extent that exceeds what would ordinarily be legal and permissible in their formal educational settings.

Interestingly enough, some medical students report that one of the real advantages and rewards of volunteer medical activity is the opportunity to practice medicine beyond the bounds of what they would be permitted to do back home. They do not tend to describe this as a moral issue, but it is clearly a significant feature of many volunteer medical experiences, and one to which several of them call attention.

Two other themes appeared quite often in response to our question about the factors influencing one’s decision to enter the medical profession. Interestingly enough, these often appeared together, or in close proximity. One was an interest in and affinity for science, in particular, the “hard sciences”—especially biology, but also anatomy, physiology, biochemistry, and even math. Several individuals simply reported loving or enjoying science, or being especially good at it. Often these same individuals also expressed an interest in helping people. The three following excerpts are perhaps the most explicit in expressing this particular conjunction of interests or inclinations.

When l was growing up I wanted to be a doctor. I wanted nothing, just because it looked like fun as a doctor-dress-up stuff. And then in my senior year of high school, when I took AP Bio, I just loved biology, and my first thing to do with it was, “Oh, I could be a doctor." And then, “Well, like, observe other people, and I went to the Dominican Republic to work at a camp over the summer [not the UF Timmy Foundation program], and just, like, seeing the doctor there, it was, like, that would
be awesome. I would like to do something like that. And recently I shadowed a resident who was working at NYU Hospital, and just, it’s intriguing, and just others such good opportunities to actually get in there and influence people’s lives, and it seems more concrete helping people than, like, being an accountant or something. It’s more tangible.

I think I’ve always known kind of since I was younger, probably starting in grade school or middle school, that I wanted to go into a profession that was helping other people in some way, and I think for me, I was strong in the sciences, and so it was kind of a natural progression for me to enter medicine as a field . . . and that’s pretty much it.

I really wanted a profession where I felt I was involved with people and felt where I was making a difference in people’s lives. I wanted something, you know, where that being involved with people involves where I got the daily contact in forming ongoing relationships. But, yeah, I guess it sounds a little sort of simplistic, but always . . . one side of my motivation. The other is, I’ve always been interested in science and medicine obviously. It’s sort of an excellent complement of those two, where it’s science-based but it’s people-driven, and so I really saw medicine as sort of a union of those two things.

The desire to help people, to make a difference, or to be of service, is probably the most common theme mentioned to explain why the individuals in our study chose to enter the field of medicine. In most cases, the emphasis is on relationships and the enjoyment or sense of satisfaction they provide. But it is also clear that for many there is a framework or context of meaning within which they understand their desire to contribute to the lives of others. That will become more evident when I report on responses regarding why our participants engage in medically-related philanthropy. However, two respondents mentioned at the outset of their interviews that they entered the field of medicine itself in significant part because of the service orientation of their religious faith tradition. In both cases, these individuals come from traditions in which there is likely to be a more explicit call or mandate to choose a life work that is congruent with the teachings of the faith than is ordinarily the case. There may be others who were equally subject to religious influence in their vocational decisions, but apparently not in an equally self-conscious way.

Before moving on, the reader may be amused to read the most distinctive answer we received to this question of why an interview subject entered the field of medicine:

Pessure. Because when I was three years old, so, I was in the third grade, they’d say, “Joey, what do you want to do,” and I’d say, “I want to be a doctor,” so by the time I was in the middle of high school I’d said that so many times that I had to be whether I wanted to be or not!

WHAT KINDS OF DOCTORS?

So, what kinds of doctors will, or have, these individuals become? With respect to the pre-med students, it is surely too early in their training to say, although the kinds of work that most of them imagine themselves doing in the future suggest that they are interested in being clinicians and that they are not thinking in terms of highly specialized practices. Some more specific interests have emerged among the medical students. One wants to be a general surgeon, another an Ob/Gyn physician. A third wants to work on infectious diseases. Most, again, envision being clinicians, and neither academicians nor highly specialized practitioners.

The cohort of 15 physicians, on the other hand, included a number of practitioners who were also teachers. A few also had administrative responsibilities.
There were six or seven pediatricians, plus a pediatric surgeon, a general practitioner, an ER physician, a cardiologist, an ophthalmologist, a specialist in internal medicine, and two pathologists. Aside from the pathologists, what may be most striking about this cohort is the number of pediatricians. No attempt was made to search out pediatricians for the study, and our data give us no basis for concluding that pediatricians are over-represented among physicians who engage in charitable medical work. I simply note that they were well represented in our study.

THE RANGE AND NATURE OF MEDICAL PHILANTHROPY

At this point I will summarize, by cohort, the range and nature of the philanthropic medical activities that the participants in our study have previously undertaken or in which they are currently engaged, beginning with the pre-medical students. As previously noted, seven of these students have participated in one or more of the medical mission trips of the Timmy Foundation. For students from the Bloomington campus on Indiana University, there is an annual opportunity to participate in one of two trips, either to Honduras or the Dominican Republic. Both trips take place during spring break and last approximately one week. In addition, most of the students in our study who had participated in these trips were also actively engaged in the fund-raising and organizational activities of the local chapter. These activities involved a commitment of perhaps 3-5 hours per week, and played an important role in securing the necessary funds and making the necessary arrangements for each annual trip. During the course of their undergraduate studies, it is possible for students to take one of these trips four times, beginning in the freshman year. Three of the seven students with Timmy experience had actually gone as freshmen. Of these three, one was planning to go again as a sophomore; the other two had already gone three times and apparently were not going as seniors. The other four students with Timmy experience had been once or twice, and at least one of these was going again.

The trips planned by the Timmy Foundation take students to third-world settings where they encounter living and health conditions radically different from those at home. They help staff day-long clinics in various villages where a local physician directs them. They may encounter ailments they have never previously seen. They help provide simple medical services, taking vital signs, dispensing medicines, trying to help the patients understand the instructions for their prescriptions or other medical care. They spend a lot of time simply listening to and interacting with the people who come from the surrounding area to these clinics. In the Dominican Republic many of the patients are Haitian workers, ineligible for any government services or other medical care. In Honduras, the students have participated in public health education, and have even been involved in building construction.

A few of the pre-med students we interviewed have had similar experience under other auspices. One volunteered for five and a half weeks one summer in the Dominican Republic, another spent six weeks during our winter in the jungle in central India. One student spent a year with her family in a different third world setting.
and, while not on volunteer assignment as such, spent a lot of time visiting with patients being seen by her physician father. Two respondents indicated volunteer experience in hospital emergency rooms, in one case going back to sevenths grade. Other experiences included candy striping, a community health clinic, and weekend visits to a camp for children with disabilities. Several individuals also indicated significant previous volunteer experience in non-medically related activities.

Among the medical students there was an even greater diversity of volunteer medical service. Few of them were currently engaged in any volunteer work, due to heavy academic demands, but all had recent volunteer experiences. One had spent six months volunteering in a Mexican hospital. Another had worked with medical teams in Guatemala on a once or twice annual basis since high school. One had recently returned from a 10-day medical mission trip to Myanmar, two others had been to Kenya for two months the previous summer. Yet another had spent a week of his summer working in a health clinic in Guatemala. Two of these students had previous experience with Timmy Foundation trips. Other current activities included volunteering on Saturday mornings at a health clinic for the homeless, being a caregiver companion for 2-3 hours/week, 3 hours/month in a rural health clinic, organizational work and participation in neighborhood health fairs, and weekly visits to an AIDS hospice. Previous involvements included candy striping, volunteering in a handicapped children's hospital, emergency rooms, an obstetrics clinic, and hospices. For most of these medical students, their medically-related volunteer experience began in high school or college, but for one it was not until medical school. A number of them also had other kinds of volunteer experience, perhaps the most important of which were church-related mission trips or overseas volunteer assignments. For three of these students, those experiences were clearly their most important volunteer experiences prior to engagement in any medically-related charitable work.

A few of the pre-med and medical students we interviewed have previously held jobs in medically-related settings. For the most part, however, the work experiences these students have had in medically-related settings have been as volunteers. Insofar as medically-related work experience is important in shaping the vocational aspirations or career goals of young people who decide to enter the profession of medicine, therefore, it would seem important that there be meaningful volunteer opportunities available for them to explore and gain experience in their prospective vocation. It would be interesting to investigate whether other pre-med and medical students are more likely to have medically-related work experiences that are remunerative, as compared to the cohorts we interviewed, or whether they are more likely simply to lack any work experience in medically-related contexts. The pre-med students we talked to gave the strong impression that medical school admissions committees look for, and view favorably, any evidence of volunteer service in the résumés of their applicants. It is not clear, however, what proportion of pre-med students actually engage in volunteer medical activity for the purpose of padding their résumés without any real, personal commitment to medical philanthropy. None of the students we talked to admitted to such expedient motivations.
Turning to the cohort of physicians, our interviews yielded very little information about the possible significance of volunteer medical activity in shaping vocational choices and aspirations. Our respondents had considerably more to say about the various sorts of philanthropic activity in which they are or have previously been engaged. I will first summarize the current work these physicians are doing, or the most recent work they have done, that appears to have commended them for this study, and then review briefly some of the previous volunteer activities in which they have been engaged. In doing so I make no pretense of providing a complete account of the extent of volunteer commitment and activity of any of these physicians. All that is reported here is based on the information, however complete or limited, that was provided to the interviewer. Moreover, as previously noted, some of these physicians are reporting on activity that either they themselves, or some of their peers, would not necessarily consider a form of medical philanthropy. I will subsequently attempt to lay out some of the issues and questions that arise from this review.

Physician A has always accepted patients without regard for ability to pay. Although the office staff may know a patient’s financial situation, A does not seek this information. A insists, moreover, that this does not qualify as medical philanthropy. Despite a career of some length, A does not mention any previous philanthropic activity. However, A is now party to the formation of a new not-for-profit organization that will serve the inhabitants of a very remote region abroad. A expects to spend a considerable amount of time living and working abroad, some of it in connection with this purely volunteer activity and part of it in providing organizational leadership for a new medical school. This will require a 50% cut in A’s clinical practice. The practice of A’s medical specialty will not be needed in the new NGO that A is helping to create. This NGO is not a medical organization, but it will provide services that will surely contribute to the public health of the population that it reaches.

Physician B is a volunteer member of the board of a non-profit AIDS service organization. B provides free physcials every summer at an HIV and AIDS camp. B also volunteers, both as an active board member and as a provider of clinical care, at a church-sponsored, neighborhood clinic that provides free acute care services to an underserved population. All told, B estimates that this represents a time commitment of approximately 15 hours per month.

Physician C is a hospital administrator. The hospital serves a largely indigent population. Salaries are significantly less than could be had at other medical institutions. C does not really think of this current position as philanthropic. C has, however, been involved in the creation of another medical institution that provides charitable medical services in a third-world setting, and continues to maintain professional relationships with others who provide medical services in that setting. C is strongly committed to providing good medical care to underserved populations.

Physician D is the primary care physician for a community health clinic, where D works 30 plus hours per week. The clinic charges a very modest flat fee for a patient visit, and gives away large quantities
of sample medications, most of them collected from other local physicians. (Drug company representatives tend to avoid the clinic, because their products are not likely to be prescribed to the clinic’s uninsured patients.) The clinic serves the working poor, persons who have some income but no health insurance, both because their jobs lack health benefits and because they cannot afford to purchase it for themselves. D estimates that income as Director of the clinic is about 20% of what a physician might ordinarily expect to receive from such work. D supplements this income by working part-time in the emergency room of the local hospital, by means of which D is also provided malpractice insurance that would otherwise be unaffordable. A few other physicians also work for the clinic on a very part-time basis, e.g., taking turns serving on-call, so that services are basically available 24/7 to the clinic’s patients, and so that D is not consumed by clinic duties. Technically speaking, D is not a volunteer, nor does D provide free medical services as a rule. D’s entire medical practice, however, is devoted to providing medical services to an underserved population. D believes it would be demeaning to offer such services for free. It is important to D and the board members of the clinic that the patients know that a portion of the fee they pay for every visit goes to pay D’s salary, so that they understand that they are giving something in return for D’s services.

Physician E has never turned away a patient due to inability to pay. E now receives a salary, working for an organization for which E volunteered part-time for some 20 years, and for two additional years full-time. E was persuaded to accept the salary for institutional reasons. In this current salaried position E is able to continue and expand on the work of 22 years as a volunteer. The organization E serves is an international provider of education and training to health care providers around the world who are in particular need. E has traveled all over the world, lecturing, teaching, and setting up medical education programs; most of it while a volunteer with the organization E continues to serve.

Physician F has taken a leading role in the community and region in providing health care services to a particular segment of the population. F works with a number of other like-minded physicians to provide quality medical care without regard to ability to pay. F estimates that 45% of those who are provided services are Medicaid patients, but seems ambivalent about construing this as philanthropic activity. F’s more clearly philanthropic efforts include a very active role as a volunteer in providing community leadership to improve delivery of health care services, staffing of health fairs, giving free sports physicals, and providing under-compensated leadership to the local hospital medical staff.

Physician G teaches and practices at a major university-based hospital that treats all its patients without regard for ability to pay. G’s primary philanthropic activity is fund-raising to promote and maintain a vital working relationship between the university-based medical institutions of which his hospital is a part and the growing facilities, programs, and educational mission of a partner institution in a third-world setting. Hundreds of medical students, residents, and teaching faculty from the United States have spent time working and teaching in this third-world setting, nurturing the relationships necessary to strengthen the indigenous medical program. G has also
spent time overseas on several occasions. Those who go to this overseas setting are remunerated, so it is not a strictly philanthropic activity on their part. However, the resources for their remuneration and other expenses of the program are provided by financial gifts to the program.

Physician H is part of a medical practice where it has been possible to work part-time. This practice is in no way philanthropic. However, it has enabled H to pursue other interests and, specifically, to volunteer and provide leadership to the board of a downtown social services organization. The population served by this organization includes many who are homeless and many who have a variety of medical or health-related problems. This volunteer work does not involve clinical practice. H's role is primarily one of organizational leadership, but also one that provides opportunity to become acquainted with the client population. H sees this work as an opportunity to learn much more about the nature and extent of the unmet medical needs in the community, and entertains the possibility that the organization may grow to expand its services in order to include primary care, or make it more accessible to this population. H estimates that this commitment currently demands 10-20 hours per week.

Physician J is currently the medical co-director of a hospice and serves on the board of an agency providing services to persons with disabilities and those who care for them. Over the years J has been extensively engaged in a variety of other kinds of medically-related volunteer activities. These include the free provision of clinical care in the absence of other physicians, on-call hospital services, care for neighborhood center clients, medical mission trips, and legislative efforts aimed to improve public health.

Physician K has joined non-physicians on church mission trips to a third-world setting and anticipates continuing to do so. In that locale, K spends evenings visiting villagers who have medical complaints, providing ad hoc medical services, and working with other health care providers in a clinic setting. On another previous occasion K participated in a more specifically medical mission, helping to run clinics in a different third-world setting.

Physician L has never refused to see a patient because of money. In L's view, trying to take care of patients is L's basic philanthropic work. L's description of L's medical practice makes it clear that L sees this work as a vocation. L also associates medical philanthropy with L's volunteer activities in the community, activities that are not specifically medically related. It appears that, being a physician in a community where L is widely known, L tends to identify the public role with the professional one. L has also previously been on a church-sponsored medical mission trip, and was expecting by the time of this writing to have gone on another.

Physician M is involved in a variety of volunteer activities. These include clinical services at a free acute care clinic, health fairs, health talks, and organizational work in support of legislation that serves the needs of children. Most of these activities are in continuity with M's job, and some of M's previous volunteer activities are now part of that job. M estimates now spending some 10-15 hours per month volunteering in
Physician N serves a population with a high proportion of uninsured. In that capacity, the practice to which N belongs writes off a significant proportion of medical bills, which diminishes the income of all the medical staff. N reports, however, “I’m not devoting any specific amount of my time to medical philanthropic work the way I would generally see that.” However, since our interview, N has assumed a medical staff position that is clearly of a more volunteer nature, serving an even more preponderantly indigent population. N is also strongly committed to health care reform, in particular, the provision of universal health coverage, belongs to an organization that advocates for a national health program, and spends a great deal of time promoting that reform.

Physician O is a clinician who is no longer in clinical practice. O continues to teach and to advocate for legislation that serves the health care needs of an important segment of the population, something O has done for many years. This advocacy work is clearly done on a volunteer basis, and currently requires some ten hours per week.

Physician P has adopted a special needs child. Part of P’s reason for doing this follows from the fact that P has specialized knowledge and skill to help take care of this child, whose medical needs have been substantial. Caring for this child, along with other children in the family, has severely limited P’s freedom to travel, including desired travel for medical mission purposes. P works in a setting where no distinction is made regarding ability to pay among patients, about one-third of whom have no insurance. Other physicians with whom P works like to spend time elsewhere providing medical services to underserved populations. This requires that P and other colleagues cover for the colleague who is gone for such purposes. P regards the coverage provided on behalf of absent colleagues so they can engage in medical missions elsewhere as a form of medical philanthropy. It appears that both P and some of P’s colleagues also tend to view the care for the special needs child as worthy of being considered a kind of medical philanthropy. The medical specialty that P practices is one that P regards as especially service oriented. P is acquainted with colleagues who have also adopted their patients.

It should be added that a number of these fifteen physicians have previously engaged in medically-related philanthropic work of great variety. At least three have previously worked with Native American populations. Some have worked in neighborhood health clinics or gone on medical mission trips not already mentioned. One spent a year volunteering in Haiti after graduation from medical school. Another worked in an African mission hospital. Another went on mission trips to Thailand and Congo. Yet another worked intensively and extensively with migrant farm workers. For a couple of these physicians, on the other hand, active involvement in medically-related philanthropy is a relatively new thing.
WHAT CONSTITUTES MEDICAL PHILANTHROPY?

If there is a single issue that is raised most pointedly and poignantly by the reports of these physicians, it is the question of how medical services to those known to be unable to pay are to be regarded. Is medical care to the indigent undeserved, or to those whose means are simply insufficient to cover the full costs of their care, a form of philanthropy or not? Several physicians noted that, as one put it, “all physicians do that, by the way.” But another physician observed, with regard to the uninsured and the under-insured, “there are plenty of physicians who choose to practice in ways that they avoid taking care of those folks.” Moreover, it seems likely that physicians in certain specialties, e.g., cosmetic surgery, or in exclusive settings, seldom have occasion to treat patients without means to pay. Yet it can still be granted that a sizeable proportion of all physicians in the practice of clinical medicine knowingly provide treatment to patients from whom they expect no remuneration. Are all of these physicians thereby philanthropists?

One physician, who practices Emergency Room medicine, declined to characterize this practice as in any way philanthropic:

I see that as part of my daily work, because in this imperfect medical system or, better, non-system, that we have in this country... the Emergency Department is one of the most important safety nets. And because we see everybody and don't request payment, and so every day in my work I see people who can't pay, and so that's a big part of what I do... but currently I'm not doing [medical philanthropic work]. ..I'm not working X number of days a month in an indigent clinic or anything like that.

A salaried physician working in a public institution gave a similar response when asked, “Would you say, with respect to your work here, that any dimension of it could be characterized as charitable medical work?”

You know, I always struggle with that. Of course, we all could be—I'm not sure all, but I guess most of us could be—doing jobs that would be paying us more if we wanted to be paid. And you know, so if I choose to work with somebody who doesn't really pay their health care bill, you know in my mind that's not charitable. Yet I have no doubts that most of the private practitioners in town will be making more money than I when they care for somebody who can't pay their health care bill, and they do view that as charitable. But personally, I don't see that as charitable. I see that as a job that I'm getting paid to do.

Still another physician, who has always accepted patients regardless of insurance or economic status, but in a for-profit setting, put the matter even more emphatically. In the context of responding to a question about the attitudes of the medical profession toward charitable medical work, this physician said:

(What we generally talk about in charity is taking care of patients who don't have any insurance or don't have any money, and most docs do that. Some don't, and some refuse Medicare, and some refuse Medicaid, all of which I think is unethical, but nonetheless that's done. ... I don't think the medical community in general encourages charity, and if you talk with most doctors they're just going to say, “Well, I do a million dollars worth of charity work each year.” Well, all that means is they write off certain amounts, but it's a bunch of baloney, quite honestly ... (A)ll that matters is the price they charge, and what Medicare pays, and they pay that difference between what Medicare pays and what they charge as charity, and that's not charity at all because—that's a long discussion here because—anyway, that's false to do it that way because charges don't mean anything in medicine anymore. Basically you can charge a million dollars, but whatever the insurance company gives you is what you get, so you
can’t take that as charity work. A lot of docs will consider it as that.

So far as I can tell, all of the physicians in this study have provided medical care, either without regard for ability to pay, or with the clear intention and desire to provide services precisely to those persons who are unable, or not fully able, to pay. We encountered no one who professed to turn away Medicare or Medicaid patients, or persons without insurance or the means to pay. A good many, on the other hand, chose to pursue their profession in contexts where a significant proportion of their patients would come from underserved populations. Some regarded their work in this regard as philanthropic, a few were more ambivalent about whether or not to count such work as charitable, and others—like those just cited—did not want to count such medical care as philanthropic at all.

In general, these physicians see it as part of a physician’s obligation to care for all people in need of their services, irrespective of payment. In one instance, payment is an issue, given the physician’s conviction that it is demeaning to offer services for free. However, the payment required in that instance is truly minimal, and serves not to exclude some patients or to enrich the physician, but to maintain a semblance of human dignity. In a few other instances, payment is an issue, but chiefly in the sense that there needs to be enough total income to pay the overall costs of providing services. Many, perhaps even most, of the physicians interviewed would agree with the physician just cited, that it is unethical to turn away patients because they cannot pay, or because their only payment is provided through Medicaid or Medicare, although no one else stated that view so explicitly.

If, indeed, physicians are morally obliged to accept and provide treatment for patients without regard for ability to pay, then such a practice can hardly be called philanthropic. It misconstrues the meaning of the word philanthropy to identify it with behavior that is characterized as morally obligatory. If, on the other hand, care for patients without regard for ability to pay is considered supererogatory, then such care may also be viewed as philanthropic. In order to derive a clear definition of the meaning of medical philanthropy, therefore, one must establish a clear sense of the extent and limits of the physician’s moral obligation to provide medical care.

Another way to frame the issue is to ask whether persons have a basic right to adequate medical care. If such a right exists, then it is principally a matter of justice to see that this right is satisfied. Justice requires that health care services are sufficiently adequate and available to meet patient health care needs. But this does not mean that the moral requirement to provide such services is a responsibility to be borne exclusively by the medical profession. Society as a whole, it may be argued, bears such a responsibility.

The question then becomes one of determining how that responsibility for health care services ought to be distributed not merely within the medical community but within the society as a whole. Viewed in this light, one might claim that the provision of needed medical services, while a requirement of justice within a particular society, may also be met in part by medically-related activities that are charitable or philanthropic. Indeed, in a society that is less than just, there is no other way to meet such needs. Medically-related
activity: that are charitable or philanthropic could then be defined as services that some physicians and other health care providers provide to a degree that exceeds their share of a just distribution of health care responsibilities within that society. Such charity or philanthropy, should be seen as supererogatory: It goes beyond the demands of simple distributive justice with respect to the physicians involved, that is, beyond or outside whatever is requisite and obligatory on their part as members of their profession and their society.

This is to state the matter simply, formally, and rather abstractly. Other questions could be pursued. For example, with respect to any particular physician, what persons is that physician obliged to regard, and thus accept, as patients? The prospective patients may not have an ailment that is encompassed by the physician’s specialty or expertise. The prospective patient may reside at some distance, or be a citizen of the Third World. Care of the prospective patient may preclude time and opportunity to care for other patients. No physician would seem to be obliged to accept every prospective patient, regardless of the circumstances. The obligation seems to be simply not to discriminate among those prospective patients whose conditions are such that the only significant difference distinguishing some of them from the others lies in the ability to pay.

There are other questions that cannot be adequately addressed here. The important point is that those physicians who see it as their obligation to—perhaps even more simply—as their job to accept all their patients without regard to payment ability are correct in recognizing that, from their perspective, this does not qualify their work as philanthropic. However, a different sort of argument can be made to the effect that, by virtue of choosing to work with an underserved, underserved, population, such that an unusually high proportion of their patients will be unable to rent for services received, a number of the physicians in this study have made a vocational choice that possesses an intrinsically philanthropic character. In effect, these physicians have assumed more than their share of the responsibility of their profession and their society for providing needed medical services to its citizens. I suspect, in fact, that the reason we were encouraged to interview certain physicians in our study derives precisely from the intuitive moral sensibility of those who counselled us that medical service to a disproportionately underserved population tends to bear a distinctively philanthropic aspect. Even if most physicians who serve the underserved nonetheless make a significant income, the fact that they could probably be making much more in some other setting and have chosen otherwise represents a kind of gift to their patients and the larger society.

The perspective I am suggesting here is surely validated in the example of the physician who directs the low-cost community clinic, receiving perhaps 20% of the income that might be gained by providing similar services in conventional medical practice. Even though this physician’s services are not provided free of charge, they are clearly provided at far less than “market cost”—that is, at less than they would cost if provided at “usual, customary, and reasonable” rates to the general population.
In other words, medical philanthropy should not be equated simply with the provision of free medical services. It may also be too simple to equate medical philanthropy with the provision of medical services for less than the going rate, however. One problem with the latter equation is that it may be a big mistake to regard the going rate as morally normative. If, in the grand scheme of things, physicians are ordinarily compensated excessively for their services, then there may be nothing particularly charitable about giving up some of that excess compensation. That is not an issue to be addressed or resolved at this point, but it exposes another dimension of the complex question regarding the proper definition of medical philanthropy.

Our interviews provoke another question regarding how medical philanthropy is to be defined, namely, to what extent such philanthropy consists in the medical nature of the services being provided. Some of those we interviewed spend significant amounts of time advocating for legislation intended to address the health care and other needs of the population they serve. In at least one case the focus of the advocacy is national health care reform, including universal health care coverage in the form of insurance or government program. In another case the physician spends a considerable amount of time working with a downtown neighborhood service agency that provides a variety of services, none of them of a clinical medical sort. Other physicians serve on the boards of social service agencies where human needs that are not necessarily medical are addressed. Nonetheless, insofar as these individuals are engaged in agencies, programs, or advocacy that relate to public health, we may speak of their volunteer activities as medically-related. In some if not most of these cases, it would not be necessary to have clinical training as a physician in order to take on these activities, but being a physician hardly hurts, as the following comment indicates:

"One of the things I tell all my students is that one of the wonderful things about being a physician is that it opens doors. I can call the superintendent of schools and say, "This is Dr. Livingston. I'd like to speak to the superintendent," and he answers the phone. If called as a parent they'd take my number and might not call back. . . . [I]f from my perspective that's a responsibility, you're given this opportunity through being a professional, to do things that other people can't do. So I feel it's a real sense of social responsibility there . . . . They'll let you do anything with an M.D. behind your name, frankly."

Clearly, physicians often enjoy a measure of social standing and influence that commands them for involvement in public issues, and particularly in health care issues. By virtue of his or her professional experience and knowledge, a physician may enjoy high credibility in making the case for health care reform, anti-smoking legislation, or child safety restraints in automobiles. Surely the case can be made, then, that the physician who also sees such involvement as a professionally-related social responsibility, and volunteers in light of that perspective, is engaged in a kind of medical philanthropy, at least where public health issues are at stake.

Moreover, there are physicians with philanthropic inclinations whose circumstances constrain them from engaging in those activities that are typically seen as forms of medical philanthropy. One physician explicitly called for re-thinking this matter:

"I think we as a community need to broaden our idea of medical philanthropy. Does that mean that we
usually physically go somewhere overseas, or go to a clinic downtown, or do we find other ways to support that idea if you are physically unable, so that it doesn’t restrict you? Be much more creative about the kinds of things that we can do. Is it just as important for someone to be the spokesperson and spearhead a fundraiser as part of their medical philanthropy as a person who actually goes to Haiti for a week and works in one of the clinics there? How can we expand it so that one isn’t admired more than another, and that both kinds of behaviors are very encouraged and supported in a positive way and not looked down upon as one’s better than the other? The work of philanthropic medicine clearly requires supporting institutional and social structures and relationships. Our conception of medical philanthropy should be expansive enough to encompass the volunteer work of physicians (and other health care providers) who indirectly make possible the direct provision of philanthropic medical services by others.

MOTIVATIONS FOR PHILANTHROPIC SERVICE

At the core of this study was a desire to learn more about what motivates physicians, and physicians-to-be, to become involved in charitable medical work. Consequently, one of the questions we asked was, “Why are you doing this? What animates or motivates you to be involved in this way?” A number of themes emerged in response to this question, two of which are especially evident in the following remarks:

I think that we, you and I, have certain gifts, and I think that we do have an obligation to use those gifts in a way that’s meaningful and contributes and, as well, I think that there is a bit of an imperative to reach out to those who are less privileged or less fortunate than you and I are. I believe that very strongly.

In exploring this question further, this physician went on to say, “I mean, you’re talking about my toilet training probably. That’s how I was wired and how I was brought up, and so, you know, there’s never any question about that.”

The themes of upbringing and obligation are perhaps the most common in all the interviews we conducted. Certainly, they were prominent among the cohort of physicians, over a third of whom

specifically mentioned parental influence. In one instance, however, the primary motivation has been a spouse. Those who

mentioned parental influences spoke in terms of upbringing, or they spoke in terms of parental example. They were taught, or perhaps showed, the importance of being involved in helping other people. The sense of obligation that was also evident in a number of responses seldom appeared to be weighty or burdensome. Only two physicians explicitly spoke of guilt as a possibly motivating factor. More often these physicians spoke of being blessed, or being motivated by a sense of service. Many of them also expressed a deep sense of enjoyment or fulfillment in what they were doing, an enjoyment that may be intrinsic to their philanthropic activity but that also often derived from the appreciation that others expressed for their services. A few even suggested that there is a selfish dimension to their philanthropic activity, inasmuch as it yields its own rewards.

The following excerpts are a selected sampling of the ways these physicians expressed themselves on this question:

Well, my parents have always been involved with lots of different things, and so I sort of grew up, you
know, being exposed to lots of different kinds of people and different sort of events and you know, being involved with our neighborhood and our church but our town, our city, and different events. So they have a real sense of being a part of a community, and the responsibility that you have to be engaged, but also to give some and money and effort. So I think that's really the main thing that I have that motivates me. I just enjoy it. I don't find it hard to say no to things that I know I'm not going to like. I find every hard to say no to things that I know I will enjoy and get something from and be able to also give something to. And all of this stuff are things that I really enjoy. So it's sort of a selfish motivation.

I was brought up with parents who were just really kind people, and we were not particularly well off, but they always helped people when they could. I remember we used to make me of my mother and tell me how she made in a way. Anybody that needed help, they would help. And that's the atmosphere I was brought up in, so I think that's natural for me to do it because she modeled it. But you get a lot... of gratitude from helping people. You don't get any money, but you sure get a lot of positive feedback. . . .

Well I suppose in a way it gives me a great deal of satisfaction. In a way that I feel that it's an obligation. . . . I teach a course, co-teach a course, in medical school. . . . one of the things I have taught and in ethics was, is, the responsibility that doctors have as far as going about their medical practice. Because I feel it's important to recognize that they have a gift. They are going to communities where they at the upper ten percent of the people, who have not only a college education but they have post-college education. Medical school, they are ten times as much as their tuition. So, and very often at same institutions, so they're obligated to go to their community to become involved and participate, and they're, you know, they're getting so much money that they ought to give money back to the community, not only, through, in, taxation. . . . So, as I say, I feel obligated to do it and I feel a lot of satisfaction. I think it's something that I feel I owe, number one, and I feel like after I get a lot out of it.

I think because it feels right. . . . I think because it's something that I feel I owe, number one, and I feel like after I get a lot out of it and not having your reimbursement be your top priority. . . . You know, I kind of grew up in a family where you're supposed to volunteer to some degree and to give back, and so I've always felt a strong need to do that.

In connection with upbringing, some physicians also mentioned their religious background. For one it was a liberal faith and upbringing, with strong emphasis on social conscience. For another it was a Catholic upbringing and schooling with a strong emphasis on service. For another it was seen as a clear mandate of the religious tradition, reinforced by parental example: “because it's what we're asked to do. . . . And so, I just, I haven't known any other way. . . .”

Yet for another, whose religious upbringing provided a basic orientation and motivation toward service, the response to our question took the form of a critique and explanation:

I think I'm a little disenchanted with the medical community and . . . I'm really disappointed with our society and government's approach to the utilization and with organized medicine's approach. I think that the resources are there if we are much well enough, and the things that are done in the typical setting are too little for the need that there's. I think if we really are part of the community, as medical people, we need to face the fact that we're delivering services to communities where one out of six people are being relatively ignored, and that was a matter of conscience that really was starting to eat at me in my bed after working at the Indian reservation and seeing a very upbeat approach to following the community's needs. I thought, you know, the resources are often in the community. They don't need to be grant-funded from way outside. You don't need to jump through so many hoops. You don't even need to research the need. It's staring you in the face, and why won't anybody do what we're doing here, and this model that's sort of working around in my mind—and I thought, I think it could be done but I don't know of anybody that's trying it quite this way, and so it was partly that mid-life restlessness of being ready to try something. You have enough background in the system to have an idea where the weak spots might
be. As it happens, it’s worked out very well. But the motivation. I think, is to serve the people who I see being least served by the medical industry, and to add an element of interest and fulfillment back into a rather routine practice of medicine. And I definitely has done that. This practice will stretch me in many ways that traditional practice didn’t.

The particular nature of medical practice in which this physician is engaged is clearly motivated by moral perceptions and judgments with respect to both our society and the medical profession, some of which are shared by other respondents. Certainly this physician is not the only one whose philanthropic activity has been profoundly shaped by such perceptions and judgments. However, in this excerpt some of the moral issues yet to be explored are brought into sharpest focus. I will return to these issues later.

There is another theme in the foregoing response not to be overlooked, however. That is the “element of interest and fulfillment.” More than one physician indicated that the practice of medicine can be limiting. It can become routinized. And in any event, several physicians indicated that their participation in philanthropic medical activity served in some way to broaden, enliven, or otherwise provide a welcome contrast to their regular duties. A similar theme was even more pronounced among the medical and premedical students, several of whom regarded their philanthropic activity as a welcome change of pace from their studies, a broadening experience of the world, a meaningful way in which to exercise their growing knowledge and skills, and so on. The following excerpts from two of the physician interviews are among the more distinctive in their emphasis on the desire to gain a broader perspective of the world. Both also implicitly raise moral questions regarding the distribution of economic, and hence, medical, resources:

I’d like to say it’s all altruism, but I think that there’s a couple of things I’ve grown up very sheltered. We lived in a nice town and my dad worked in the city. I’ve never had much of my own experience with people that had different names, and I think I’ve always wanted to be involved in some way. But I didn’t sort of stumble upon opportunity, and his kind of presented itself to me, and I thought that maybe I had something to contribute to that. I think that also I’ve been struggling with just trying to figure out what’s a comfortable lifestyle. It seems, you know, as a physician you are allowed to live very comfortably, because physicians can make you know, a good living. I think that I struggled a little bit of finding my comfort zone in that, what’s appropriate for me to make? What do I need to give back? And just looking at the unequal distribution of resources, and kind of figuring out what my role is and all of that, so I definitely have those kind of struggles.

I think there’s a lot of things and most of them, quite honestly, are pretty selfish. I’ve had the opportunity to go to Europe. You know, they talk about seeing the world. But you really think about it, if you go to London and Paris and those places, it’s a lot like going to New York and Chicago. If you want to see the world, go to Central America or, you know, to Africa, places like that. So some of it is just a sense of broadening and going places and seeing things that you’ve never gone to before. The trips that our church does, it’s about half and half adults and high school kids, and so my oldest daughter has gone with me and the most recent trip my youngest child has gone, and I think some of it is to get them to recognize that you know, the way you live is not the way most of the world lives.

So some of it is just to kind of see the world. I will conclude this review of physician responses to the question of motivation with an excerpt from an interview with a physician whose volunteer activity has obviously been highly engaging and, though not evident in these comments, one that has provided many experiences in other kinds of places:

I would look at it almost the other way around.
couldn’t conceive not doing it. It’s not work, it’s fun. It’s like that Boy’s Town thing where it said, “He ain’t heavy, he’s my brother.” It’s just fun. And anything, I’m doing I’m getting back double or triple. It’s just that kind of a eureka phenomenon and, you know, he million other legitimate logical reasons—it’s just the right thing to do, people need it, it’s only fair to pay back when you’ve gotten so much, it’s—the Hippocratic Oath says you’re supposed to teach the children of your colleagues and mentors. I mean, there’s no even remote logical reason why a person shouldn’t be doing this. But he doesn’t have to. You don’t have to do it, but if you have the remotest inclination you just should do it.

To summarize: the physicians in our study told us that their philanthropic activity was motivated by a number of factors, one of which was the influence of parents and, in several cases, religious communities in their upbringing. There was also frequent mention of the sense of obligation, or desire to give back, born of a recognition that one has been privileged, or blessed, by family, circumstance, and other life conditions. For some physicians, the simple fact that they find enjoyment in their volunteer or philanthropic activity goes a long way toward explaining why they do it. For others there is also the fact that what they are doing makes their lives more interesting and fulfilling, by enriching their experience, presenting them with new challenges, requiring of them, new learning, and so on. In several instances, the sense of obligation was framed not merely in personal terms, as a response to what one has received, but in terms of what could be called issues of social justice. Moreover, the extent to which these physicians have focused their efforts on underserved populations suggests that the great majority, if not all, of them, are in some way motivated to help redress the current mal-distribution of access to health care resources. Finally, a theme that emerges more prominently in the interviews with pre-medical and medical students is that of the appreciation and gratitude that those who are recipients of philanthropic services typically express. When asked later in the interviews about the personal rewards of their philanthropic service, these physicians spoke most often about the sense of personal satisfaction that came from their work, the positive relationships and expressions of appreciation from those receiving their services, and the good feeling that comes from being able to make their contributions or the knowledge that they are doing the right thing.

When we turn to the responses provided by medical students to the question of philanthropic motivation, these themes appear, though with varying frequencies. Parental influence and upbringing, religious background, and the desire or sense of obligation to help other people are all important. So is personal enjoyment and the satisfaction of helping others. Then there is also the value of the learning experience that is integral to most charitable medical activity, a benefit that is less emphasized by practicing physicians. The following excerpts are among the best at expressing these themes. The first comes from someone who grew up in Guatemala.

Number one, I love it. I love living in Guatemala. I love working with the poor people. And really feel at home there, and so I love my excuse to go back and help out. And I also love medicine a lot. And partially, because I am, I have a relationship with God, you know. I’m a Christian, and I believe when Jesus said, you know, the thing you do for the least of these you do for me, and what this means, and so I—and it’s not so much like I feel like I have to obey that command to do things for the poor, but I love to do it, it’s fun and it’s rewarding—so it’s not really, I don’t know, a challenge or whatever.

Part of that I would have to believe is in the way that I was raised. My parents have always volunteered for projects at church, projects at school, projects in
the community, and so I just grew up in an environment where that was something that you did because that was what it meant to be part of a community or part of a church, part of a group. And so I had to say that my parents probably had a big influence, and that they instilled in me the desire to feel like you don’t want to just be part of a group but you actually want to participate in a group you want to have a role in.

I kind of want to help out and do anything that I can. I just kind of feel an obligation to do that. I like St. Elna Clinic because it’s for underprivileged type patients. People in a rural area who don’t, if they kind of don’t have this clinic, then their other option is really to go to a hospital and emergency room. They can’t really pay for outpatient visits, so it’s a really good service to them and it is, I mean, in the more selfish kind of way, it is a really good way for me to learn. So I am able to kind of build my skills, build my own confidence, and do something good for them.

I think now that there’s so much school time, class time, it’s really easy to lose focus of why you’re doing it, of the reason why you got into it in the beginning, of helping people. You know, when you’re just sitting at textbooks all day and reading, reading, reading about disease, pathology, all these things. When you go back and you see patients and you interact with them in a home-based clinic or something like that and you can make a difference and you can affect somebody’s day is a positive way, it gets you back on track. Back to some of that realism. But again, it’s a real balance, because, and even though it fulfills me now, I feel like it’s not my place that I need to dedicate my time and energy towards learning, so it’s the balance.

The last of these excerpts identifies an issue that also emerged in some of the interviews with pre-medical students. The issue is one of how to sustain the motivation, or the aspiration, that has led one to pursue a medical career. In part it is a question of how to achieve some balance in one’s life, so that all is not classroom academics. But the question goes beyond finding time for extracurricular activities. It is the question of how to keep alive the animating impulse that a good many students identified as integral to their desire to become physicians, the impulse to help people, to be of service to those in need. As one of the medical students put it:

I think that it would be really interesting if there’s a link to medical work and dedication to philanthropic activities, before medical school, during medical school, and then after. And I would if it is a natural dip while people are in medical school, and then they rebound back to doing medical philanthropic work after, and I think that’s coming from a corner of my own work because I have seen this dip now. You know, I believe in my heart that it’s something, that I came to medical school knowing that I wanted to do some good, and I’m quite sure that I will when I’m out and practicing, that I will take time for it. But sometimes in the back of my head I do worry—since now it’s so busy, it’s so hard to find time to do that, but if that continues over after medical school when, you know, you end up never making the time. So I think that’s something that interests me.

The obvious concern of this student is that the high academic demands of medical training may erode the interest in, and commitment to, philanthropic medical activity with which many medical students began their studies. I take this to be a matter for serious concern, not just the chafing of a student under academic pressure. The medical student cohort presented us with the greatest difficulty so far as scheduling interviews was concerned. More than once I heard statements, even lamentations, that the first two years of medical school in particular are so intense that time is left for little else. Most of the charitable medical work being done by medical students either took place in the summer or over some other break period. No medical student reported devoting more than 2-3 hours per week to volunteer activity, and most reported no ongoing activity. While the student just quoted acknowledged the importance of the academic knowledge they must acquire, this
student and others clearly felt the need not to be consumed by their studies.

One student who volunteers a couple of hours each week said of this activity, "It certainly hasn't detracted from any of my studies. It's definitely enhanced them, I think. Like I said, but the caveat that I've made sure I haven't bitten off more than I can chew." Another held a decidedly more critical perspective on the way medical education is currently structured:

There's a lot of extraneous stuff that I think we're put through that we don't necessarily get a lot out of. And I think if kind of the administration and teachers were more focused on the important aspects, then they could integrate in some other things like volunteering in clinical aspects that we could learn a lot more from rather than just sitting in class, but it takes a lot of effort, and a lot of times I think they try and do the best they can but it's a real beast to tackle. And, I mean, I guess maybe I'm naive to think that most doctors go in the profession for close to the same reasons I do, and I think I've seen that in a lot of the students around me. I'm only exposed to about 27 others at this point, but I think a lot of them are going into it for very good reasons.

Without trying to come to any judgment about the validity of this medical student's observations, it can still be said that an important issue regarding the nature and content of medical education is implicitly raised by the concerns that several medical students expressed regarding opportunities for volunteer medical activity during the course of their studies. Just as medical school education is a socializing process, the question is whether this process works against, or in any case fails to support, the values, interests, and commitments that are conducive to philanthropic medical practice. One of the physicians we interviewed very explicitly expressed the view that medical education is not geared toward cultivating the philanthropic spirit:

I know plenty of other physicians who have a very strong service identity in their thinking. My personal take on it is, I think that the medical socializing process in the educational and practice years tends to train that out of you, and they don't inspire in you. But there are voices out of organized medicine that are really promoting that. . . . I think it was more of an identity in the middle part of the twentieth century, but I think it's been eroded badly in the last few decades.

If this physician and some of the physicians-in-training we interviewed are correct, then there is reason for medical educators and supporters of philanthropy to take a critical look at the current status and practice of medical education with regard to the vocational values of the medical profession. It is said to gainay the importance that some opportunity for involvement in volunteer, medically-related activity has had in shaping the vocational aspirations of most of the undergraduate pre-med students in our study. The following excerpt provides the most comprehensive statement of motivation for involvement in such activity, and touches on most of the reasons thus the students we interviewed have given for their own involvements:

I was just looking for some sort of experience, I wanted to do something. I wanted to do it out of the country, and I was hoping that it would be somehow health related because I thought, you know, maybe if I went on this trip I could finally decide whether I wanted to go to med school or not. Whether I was really interested in medicine, like I said, a family friend just brought up the idea. It sounded really interesting. I researched the tribal community online. . . . [It] was going to a completely different culture. . . . And that was the culture aspect that drew me in, and then as far as the medical aspect, like, it was just the opportunity where I knew I could go there with no medical training besides the EMIT training that I've had, and that would let me do things that I've never done before. They would let me see things that you know, that I would never see except in a textbook in America, so that sort of drew me in.
guess, for personal gain, and then I like helping people...

("It’s true, like I love it if I can go somewhere and do something and if people benefit because of it and it’s obviously not just a one-way street. I probably got more out of it than they did, but that wasn’t my intention going in. Yeah, and it was also just really neat to see their style of medicine. I wanted to see what it was like when doctors have no resources, they have no materials, and here they are presented with these cases. Like, what do you do in that situation? So it was just interesting to see how in the U.S. you have thousands or you have millions of drugs and medicines that you could use to treat patients, and all these different tests and different procedures, and there we had nothing. We had these 35 medicines prescribed by WHO and you treat everything with that so there’s just sort of an intellectual challenge, and that’s fun.

Note the themes that are sounded here: doing something that helps other people, having a broadening experience, being immersed in another culture, relating to and interacting with patients, learning by doing (including medical practice that would be prohibited to someone with so little formal training in the U.S.), being intellectually challenged, and having fun to boot. This student obviously had an interesting, enjoyable, and educational experience, but it was more than that. It was also an experience that provided hands-on opportunity to engage in at least a minimal level of medical practice. This particular statement expresses no clear sense of obligation, or need to give back, as there was in the responses of some others, but it otherwise touches on all the major motivations for medical philanthropy that emerged from our interviews with undergraduates.

Clearly, the motivations for becoming involved in volunteer medical work are not entirely philanthropic. The following excerpt from another pre-med student accents the value to the student of a volunteer experience, but also indicates that such an experience can lead to a more philanthropic orientation.

("As a pre-med student you don’t get too many interactions or opportunities where you can reach out to people and help out with the knowledge or things like that until you actually get into the medical field, so when I first did it, it was trying to sort of get a feel for medicine, and a little bit more than you’re legally allowed to there in the US, and now it’s kind of come that I really just sort of like reaching out and helping people that need the assistance, and sort of feel that medicine should be something that’s offered to everyone, that it shouldn’t just be pettye that can afford it, so that’s kind of what’s come to how I enjoy it now at this point.

Other motives may also be at work in the initial involvement in volunteer medical work. For one student it was a sense of obligation: “When I started doing it, it was more something that I thought I should do, and now it’s more something that I want to do.” For another it was an opportunity to have fun.

Well, initially I got involved because I thought it would be fun to go to a different country, but then after-and I knew it was going to be hard work and I wasn’t entirely looking forward to the heart of it—but then after seeing and, like, experiencing the rewards that you get from being there and from seeing, like, getting to meet people and interact with them and see how appreciative they are, that really is kind of what got me hooked. It made me want to be able to do more for them because they were so grateful for the smallest things.

As noted above, undergraduate students are encouraged to believe that volunteer medically-related experiences are viewed favorably by medical school admissions committees. Nonetheless, only one undergraduate acknowledged this as a personal motivation for involvement: "Well, I think initially you do it because it’s
expected, and then you like it, and so you keep doing it." The important point here is that for some students, the instrumental value of volunteer medical activity can be transmuted into an intrinsic value. Although a number of the undergraduates we interviewed were skeptical about the motivations of some of their fellow pre-med students for participating in volunteer activities, none of them expressed any misgivings about being expected or at least encouraged to have some evidence of philanthropic medical work on their resumes.

The kind of tension that we saw expressed by some of the medical students between academic demands and personal vocational orientation was given particularly forceful definition and perspective in the following terms:

"There are sort of two types of pre-medical students that I've met, and the large majority of them. Which is... I guess the reason I'm not a biochemist or chemistry major, is because it's so competitive, and I feel like those students are lacking in the task of which they're doing this. It comes down to test scores and... you know, getting the top MCAT score and... it's all these short term goals that I can't do. I mean, I'm a very competitive person. I want to get the best grade in the class, etc., but there's something more that drives me—more the fact that I want to do that, so that I can do this... I don't want to speak for all these other people, but when you get into that competitive drive, I mean, it happens. When you have honors classes with 40 kids, everyone knows everyone and how everyone does on the test and that kind of thing, and I think it's very hard to be a pre-med student here just because of that competition. And everyone is always worried they're not going to get into medical school, etc., and being a pre-med student, I think, doesn't affect your relationship with other students. You become very competitive. And granted, there's some cooperative learning, it's sort of a cover, almost a mask, for this, like, competitive I can't know—it's kind of a cynical view of pre-med students. But... you know, I'll have classes with these kids that I'm in the Timmy Foundation with, and you do realize that there's much more beyond why people are doing what they are doing in the classroom, and I think the Timmy Foundation has sort of opened doors that I wouldn't have had, had I just sat next to the person in a classroom, but going to Dominicans with them and talking to them and... I want to do this kind of medicine because of this and I want to do this because of this. And you get really opened up a lot, and then as far as other relationships, people that don't really identify with the whole mission of the Timmy Foundation, it's very, very hard to explain to other people, and if someone doesn't necessarily see this—I don't know, it's very weird. If you just don't get it, then it's very hard. Like you've got to drag someone to Dominicans and you're like, okay, just be here for a week, and this is what it's all about... The is, understandably, a somewhat more idealistic bent among the pre-med students than among the other two cohorts of our study. Some of that idealism is reflected in the responses these students provided regarding the rewards of their charitable medical work. For several of them, the personal dimension of that work, in particular the warmth, friendship, gratitude, and appreciation shown them by those to whom they have provided services, has meant a great deal. Their involvement in charitable medical activity has been a feel-good experience. At the same time, the volunteer experiences of these students have clearly tempered their idealism. When asked how their thinking about medical philanthropy has changed, some were quick to note that they no longer think they can save the world, indeed, that their contributions may be very minimal in the larger scheme of things. But this tempering has not turned them into cynics or doubters about the importance of helping other people in philanthropic ways. On the one hand, it has led them to think about the value of making a difference in the life of one person at a time. On the other hand, for a significant proportion of them, with their exposure to
the unmet medical needs of underserved populations, they have come to recognize the need for some sort of major change in the American, and world, health care situation. The same is true, of course, for most of the medical students and physicians in our study. I will return to this issue below.

One other benefit or reward of philanthropic medical activity that several students mentioned, also alluded to in the excerpt above, is that of the relationships and bonds of friendship that are forged among peers who have shared a common volunteer experience. While we may be inclined to regard diversity of experiences among a cohort of students as a positive value, there can also clearly be a positive value that accompanies a commonality of experience. Intentional efforts directed toward the moral formation of pre-medical and medical students, aiming to instill a philanthropic orientation or commitment, should take into account the evident importance of peer relationships and shared experiences.

WHAT KINDS OF MOTIVATIONS?

In this study we were interested in how our subjects understood the nature of their motivations to engage in medical philanthropy. So we asked them whether they considered their motivations to be primarily religious, moral, or political, or whether they would describe their motivations in some other terms. Given the way the question was framed, most respondents limited themselves to these three possibilities, and virtually everyone saw a moral dimension to their motivations. Typically, the respondent initially zeroed in on the moral, sometimes brushing over the religious and the political. Often this moral motivation was closely identified with religious values or commitments, however, and sometimes also with political concerns. The following response is in many ways representative of how the physicians, as a whole, described their motivations:

I think probably all three of those things. I’m a religious person. I’ve always been a part of organized religion, and I think part of what my parents have done is because they were part of a religion, but very few of the things I do are, you know, religiously based...[B]ut I think that that definitely is maybe the underlying basis for all of this...Definitely moral. I think it’s the right thing to do, I think this world would be a much better if it if everybody could be driven by a little bit of sense of responsibility for others as well as that guilt that makes you want to do a little more. Political? Yeah, probably. Definitely this last election inspired some very strong feelings and made me want to kind of see my case and do what I’m doing even more than I did before. But again, it’s not under any political guise... And I certainly don’t have any political aspirations.

Several physicians, discounting the religious, focused on the moral and political. The following was one of the more striking in its political perspective:

With me I think it’s a combination of more moral and political. Political in the sense that this is a place that has no government. It’s a place that the U.S. has forgotten. It’s a place that most countries of the world have forgotten, but for sure the U.S. has forgotten. It’s a place where the U.S. supported a dictatorship for 10 years who stole everything from the people...[S]o it’s a combination, I think. Moral in a sense that I’ve been blessed, I’ve been lucky. I’m looking, to give something back. And political.

It was equally common to link the religious and the moral, however, and to
eschew the political, as in the following:

Certainly not political. I can’t think of any political motivation there. . . . I think the religious and moral stuff are pretty much hand-in-hand, and . . . that you will find people that do these things that feel that it’s the moral thing to do, that have no sense of religion, don’t have a theological viewpoint at all. It’s just more a pure morality thing. And other people who have their religious views and their morality are pretty much tied together. And I suspect that I’m probably along those lines.

Several respondents resisted the attempt to distinguish among motivations, to parse the religious, moral, and/or political. “Oh, you’re trying to separate religious and moral, huh?” was one physician’s initial response. Another responded, reflectively:

Well, does one differentiate between political and spiritual? I don’t think you can. As least I hope you wouldn’t. And moral and political and religious? My motivations, I would say, are almost certainly rooted in my faith, and I have no doubt about that. Now of course what I mean when I say “my faith” probably means something different to me than it does to you, or anyone else . . . . I think it is my Catholic, my Christian upbringing that enables me, or makes me—depending on your perspective—to perceive the world, you know, through a certain color eyeglass, and that’s the paradigm that I use.

For several of the physicians in our study, religion provides a basis or worldview that helps to order their perceptions, judgments, moral and/or political convictions. For some, the religious motivation appears to be primary. For others it serves as a kind of background, or a source of reinforcement for basic moral values or political sensibilities. And for still others, religion and morality go hand in hand. For other physicians, moral convictions are primary, and religion is seen as relatively insignificant. In some cases, the moral motivation was expressed almost exclusively in terms of a personal sense of indebtedness or obligation, a desire to give back. At the same time, the moral motivation could be stated simply in less personal terms: “it’s the right thing to do.” For others the moral motivations shaded into the political, inasmuch as social and political changes were perceived as necessary to act upon their moral values. At least three of the pediatricians in the study, for example, explicitly linked the motivations for their political activity with their concerns regarding health care services for children. As one of them put it, “We got involved in some political issues in trying to fight for reimbursement so we can take care of kids and provide for the right care of kids, but that’s the only political motivation.” For at least two or three physicians, none of whom viewed their motivation as primarily religious, the moral was nonetheless metaphysical, as the following statement indicates: “I do think that we are put on this earth to fulfill some sort of role and I can’t think of any role that’s more important than helping another human being.”

Finally, one physician saw all three kinds of motivations as one piece with morality:

It’s a matter of morality or ethics. I think it’s the right thing to do . . . . That you’re in a position to do some good to somebody, then you’ve got to do it. It has everything to do with religion, it has everything to do with politics, but it has nothing to do with these either. I mean, politics is a way cut be a part of doing good for people. Religion has to do with attitudes in terms of, you know, the Christian ideal is you love your fellow man and you treat him as you’d want to be treated yourself. But very basically, it’s something that you owe . . . .

On this question of the kinds of motivations that animate their philanthropic medical activity, we find considerable similarity in the patterns of responses of the
medical and pre-medical students. A number of them are fairly quick to disclaim any religious or political motivation, others link the religious and the moral, only a few identify with all three kinds of motivations, and none emphasize the moral and political exclusively. A few of these students assert the primacy of their religious motivations to an extent not found among the physicians.

The following excerpts are two of the clearest expressions from medical students of primarily moral motivations:

I would not say they’re religious, and I would not say they’re political, so I suppose that leaves moral, and I think that that’s true. I think doing volunteer work, or dedicating time to doing the right thing, I think that is something that I would believe in, knowing what was right and wrong, and I think that it is the right thing, kind of the moral thing to do. To go down and help people who don’t have access to care, who don’t have health insurance, who need somebody to discuss things with, that it is a moral thing. It feels like an obligation to some degree.

I would not say that they are religious, I would not say they are political. I guess the closest word to describe them would be moral. . . . I feel like I have been very blessed in my own life. Maybe that’s kind of a religious statement to make, but not really. I just feel that I have a lot that I can offer, and I have been given so much, and it’s really just kind of an inexplicable need to give back, I suppose. Just something I feel like I need to do. . . .

Another medical student expressed a decidedly but not exclusively religious motivation in these words:

I would say probably a combination of religious and moral, although I don’t really like the word religion, so I tend to stay away from that, because to me my faith is a relationship, it’s not a religion, and I think that there are a lot of negative things associated with the word religion. . . . I feel like I do have a moral sense that we have so much wealth and such a surplus of well-trained physicians in this country that I feel that it would be morally wrong to not share that talent and that knowledge with people in other countries that don’t have access to it like we do. So I’d say it’s a combination, but obviously, I mean my main driving factor for me is my faith and my relationship with Jesus Christ, so you know I guess if you need to classify it, you could classify it as religious, although I just don’t like that word very much.

Only one medical student attempted to bring together all three kinds of motivation, and only to a very limited extent:

Well, the trips that I’ve actually done medically-related have not been with a religious organization, but I can’t say that my motivation isn’t religious. As I said before, I think serving is a fundamental part of Christianity. Not only serving, but serving in love, and so that’s a definite motivation. And along with that I feel that that’s my standard of morals, and there are some people in dire need out there that I’m not content just to stand by and watch and hope that someone else goes and helps. . . . And as for political, I’m not, not the most politically involved person, but immediately, I don’t know that you could take that out of motivation. Maybe realizing that, oh well, something does need to be done here, so I guess that could be an involving motivation that has not yet been fully realized. So, but just initially, religion and morals definitely are my motivation for doing this.

On the whole, the responses from medical students regarding the nature of their motivations suggest that they are unpracticed when it comes to reflecting on those motivations in terms of the categories of the religious, the moral, and the political. Some had very little to say, and some were uneasy about using these categories to describe themselves. The same was perhaps even more true with regard to the pre-medical students. One pre-medical student responded to the question about motivations in these words:

Well, I’m not religious at all, so they’re not religious, and they’re not political. . . . I guess I just always thought of myself as being one of the luckiest people in the world. . . . I just feel like it’s something everyone should be doing. It’s just part of being a
human being, is that you just do stuff with other humans. . . . I just feel like people should be out there helping people who aren’t as lucky as they are.

The response of another pre-medical student who had some similar things to say, however, indicated some prior reflection on, and discomfort with, certain categories of thought relevant to our inquiry:

I just feel like it’s just something that I should do. Like—I don’t want to even feel any responsibility, because I’d feel like these kind of things should just be what people do. . . . I don’t really like the word charity. . . . I like using solidarity, because I feel like you should just do . . . it, and not even think about it. Just love your neighbor and love and help people. You know, just—yeah, so after doing this work, has kind of made it a little bit, also, a religious motivation too, I guess. It’s made me more spiritual.

Another student, from whom the category of the moral was not so problematic, emphasized the importance of family upbringing and then went on to say, “everyone in their life has a kind of a duty to somehow help their fellow man or fellow woman, you know, and . . . in some way make the world when they leave a better place than when they came, so I think that’s pretty much the driving moral force, I guess.”

The following response was the most explicit provided by the pre-medical students in bringing together all three kinds of motivation:

We had a discussion in my family about health care, whatever. But I just, I think maybe it’s a combination of those three. I can’t explain it.

What conclusions, if any, can be drawn regarding the nature of the motivations that prompt our subjects to become engaged in philanthropic medical activity? Most of them clearly view their predominant motivations to be moral. Many of them, however, also regard their motivations to be religious, and in some cases, the religious motivation predominates. Political motivations are also seen as relevant to a number of the physicians, but only one or two of the medical and pre-medical students could articulate their motivations in political terms. However, a number of the students expressed their sense of their own moral motivations in terms that clearly have political implications. They are motivated by what they see as needs for health care that exist in large part due to significant social and economic disparities. In the first place, these needs have a moral claim on them, as they do for the physicians. But in the second place, many of the students also recognize, though they do not always well articulate, the injustice of the circumstances that give rise to disparities in health care access and resources. If nothing else, a number of them express a sense of fundamental fairness, the instantiation of which is that those who have an abundance of resources, or those who have been blessed, are obligated to share with those who lack the resources and the care that they need.

Of no less significance than the character of their motivations are the issues that have arisen for these physicians and physicians-in-training in the course of their engagement in philanthropic medical activities.
MORAL ISSUES OCCASIONED BY PHILANTHROPIC MEDICAL WORK

The physicians we interviewed told us of a number of important issues that have engaged them in their medically-related philanthropic activities. Some of these issues are of a primarily personal or professional nature. Time has been a significant issue for many of them, as it is also for the medical and pre-medical students. Time may be seen as a personal issue with respect to family relationships and obligations. It is also a professional issue inasmuch as the practice of medicine often demands long hours and requires physicians regularly to be on call. Time is also an issue with respect to the constraints it places on a physician's freedom and availability for involvement in charitable medical work.

Because time is such a ubiquitous problem in professional life, I will not attempt to describe its importance to physicians in any detail. There are two interesting and important observations to make here with respect to time and availability for medical philanthropy, however. The first is that physicians who are engaged in full-time clinical practice appear to be less likely to find time for volunteer charitable medical work than others. This is especially true for physicians who do not belong to a group practice where it is possible to have care of one's patients covered by other physicians on a regular basis. The second observation is that several of the physicians we interviewed have made conscious decisions not to be employed full-time, and they have done so at least in part in order to engage in what is regarded here as medically-related philanthropic activity. One physician has ceased clinical practice, but continues to teach and spend significant amounts of time advocating for the patient population this physician previously served as a clinician. Another has gone to approximately half-time, in part because the pursuit of other interests and needs seems more important than the additional income, in part in order to contribute a large amount of time to volunteer work. Yet another physician was in the process of cutting back hours to something like three days a week in order to have a better balance of time for volunteer activities and community and family involvements. Still another was contemplating a major shift to approximately half-time in order to take up two new responsibilities, one of them a major philanthropic undertaking. Those we interviewed also included two or three physicians, well past the standard age of retirement, who continue to be employed but presumably have significant discretion over the allocation of their time.

Perhaps it goes without saying that any physician in a conventional medical practice would not need to work full-time in order to provide for life's necessities. As one physician who is employed by a larger medical group put it, "what's happened with my life . . . is that the people in our group who ran the business end of it have actually caused me to become wealthy, which I probably wouldn't have done myself." The point was that wealth had come despite a lack of pecuniary ambition, not that it would have been difficult to achieve without belonging to a group practice. Moreover, for the physician in question, who is not yet of retirement age, a significantly lesser income would have sufficed in meeting personal and family expectations and needs. It may be the
case that many if not most physicians are in positions or practices where anything less than full-time employment is hardly an option. Clearly, however, there are medical practices where physicians can choose to reduce their hours in order to pursue other aspirations. And clearly, most physicians do not need to be making as much money as they are. In medicine, as in most other areas of life, the issue of time is often—though not exclusively—an issue of priorities.

If there are any structural problems with respect to time that are perceived to be unique to the medical profession, our interview questions were not designed to ferret out such information. It is evident that certain types of physicians, for example, obstetricians or cardiologists, are bound to have critical constraints on their time, due to the inherent limits on scheduling the demand for their particular services. Those physicians who are in the position to exercise greater control over their work schedules will obviously be at greater liberty to commit themselves to regular participation in volunteer medical activity.

Before trying to focus on specific moral issues that our physician cohort identified, it seems salutary to report the response, given by one physician who works in a setting that serves a predominantly uninsured, indigent population, in response to the question, “What issues might be raised by your work?”

Well, let’s see, I mean, you name it. Where do my kids go to school? How I’m comfortable with that. What sort of careers and choices my children make...right down to what sort of car I purchase...[I]t raises all sorts of issues related to access to health care, universal health insurance, it’s everything. I mean, it’s everything. I can’t differentiate between them. You know, what we’re doing in Iraq. Is that right or wrong? I mean, nobody—yeah, that’s pretty extreme—but nobody who has had the experience I’ve had, nobody who’s had the experience I’ve had would ever have been supportive of Bush going into Iraq. Never would have, never, ever...I could name a billion things. Go through the course of the day, it’s all those issues...I got a little excited there. Sorry.

I cite this passage not only for its intensity, but as a caveat regarding the finite list of issues to be mentioned below. It is not possible to be exhaustive in describing the evident significance that philanthropically-radically-related activity has had for the 35 physicians and physicians-in-training we interviewed for this study. In many cases they have had life-transforming experiences, only small hints of which were evident in the interviews, and even less in the transcripts. On the one hand, therefore, the issues reviewed here stand out because of the way in which they were presented, or the frequency with which they were mentioned, or the relevance they appear to have to the overall conception and purpose of this study. On the other hand, there were other issues mentioned that may be of comparable significance, but which must be neglected here.

The passage cited above also serves as a reminder that for a number of these physicians it would be very difficult to separate their personal and professional identities, or their formal work responsibilities from their philanthropic commitments. That is to say, a sense of vocation permeates and helps to unify their life and work. Their philanthropic activity is not a mere complement to their ordinary work, or some kind of adjunct to their professional life. It is all of a piece. This is not true to the same degree for all of the physicians interviewed by any means, but is sufficiently true for enough of them to warrant our attention.
DOING GOOD

As I have noted earlier in the discussion about motivations, the physicians and physicians-in-training whom we interviewed not only want to do the right thing, they want to help people, and they want to make a difference. It is no surprise, then, that one of the issues several of them mentioned had to do with whether their philanthropic activities were actually making a difference, or doing any good. One physician described at length a very frustrating experience on a medical mission trip to Zaire. Many of the people being treated had leprosy or tuberculosis. Effective treatment required long-term drug therapy. Patients might be rid of their active TB while hospitalized, but would then return home, where they lived in mud huts with an extended family, other members of whom also had leprosy or TB. Moreover, many of the patients would stop taking their medications after leaving the hospital. “I found out the diseases were not medical problems,” this physician reported. “They were social problems.” In short, all the medical efforts were of no avail. “You had to solve the social problem before you solved any of the medical problems. The medicine can’t do it.”

This particular experience accentuated one facet of a much larger issue raised by another physician, whose skepticism about the value of medical mission efforts was far more generalized:

[As I think about working in places like Africa and want not, you know, educating women, creating legal structures, and really working hard on the legal structures that uphold democratic values are in many ways much more important than health care to a place like Zaire. . . .]

[The first time I went to Zaire I went for a month and did one of those medical brigades that you hear about all the time. You know, you kind of go in and do your medical care and put yourself on the back and feel real good about what you did, and you walk out and you think, ‘Oh, wasn’t that great,’ and in reality, of course what I did, there was work outside the indigenous system. I came in and I kind of magnified the idea of great American doctor coming in to deliver health care to the poor . . .]

[Looking back on it, it’s just totally embarrassing that I would ever have participated, and so now I think health care much more in the context of development and development of communities, societies, democracies and systems. I think much more in a systems perspective now than I did in the charitable giving type of perspective. . . .]

All these medical type of brigades, I think, are really sad. I think the same, you know, when folks come to KLM Health Center, you know, and they do the kind of drop in, drop out experiences, especially for medical students. I don’t think they do any harm, and that’s good—unlike the thing in Orland, or in Entaro. But you know they’re just purely educational. Almost purely educational. Sometimes you can develop a relationship or two, but even there it needs to be so paternalistic there’s not really a certain amount of partnership. And any rate, I think as long as you’re working within systems you’re kind of on the right track, and that’s my feeling.

Although no one else expressed as jaundiced a view about the value of medical missions and health clinics, quite a number of respondents raised questions or noted problems about the lack of continuity of care in most such efforts:

I think the most frustrating is not having continuity with the patients. Like, we go for a week to see them, and then what? You know they go back to their lives, and maybe they don’t keep taking their medicine, maybe they don’t take care of their incision, maybe, you know, I mean, you just don’t know—you lose track of them. So that really bothers me, that there’s not continuity or follow up. And a lot of times we’re rushing to see so many people that you don’t take the time to adequately listen, adequately explore, truly diagnose and treat. You know, it’s more of a rush thing, and I feel like it’s sometimes half done, not done . . . And one other thing that’s really frustrating is a lot of time there’s just not enough time to see everybody.
Several students who had been on week-long mission trips, including this one, expressed the feeling that in the future they would like to go somewhere for longer periods of time. Others, by way of affirming the value of such episodic interventions, observed that people they had met and helped on a trip in a preceding year remembered them when they returned, or that they have come to know certain people who are regulars at the neighborhood health clinic. The least satisfying of these sorts of experiences were clearly those where there was little evidence that the charitable medical activities resulted in any lasting health improvements.

A distinction was also noted by one or two physicians regarding the value of different sorts of medical interventions. The ophthalmologist who can provide needed lenses, or the surgeon who can permanently correct a physical problem, or the dentist who can remove or repair decaying teeth, was seen as able to make a lasting difference in ways that the typical medical doctor often cannot. As one physician who has been on several mission trips observed, one of the greatest frustrations has been the encounter with persons whose medical problems cannot be resolved within the existing social system and the limited resources at hand.

In short, there are inherent ambiguities and obstacles in the provision of effective medical care in many philanthropic undertakings. The issues are not only practical and medical, but also moral. One of the medical students who has had both overseas medical mission trip and rural health clinic experience made the following observations regarding the various issues raised by that activity:

I enjoy going abroad and that sort of thing, you know. 'Why go abroad and do medicine and provide care there when there are so many people here? . . . I kind of picture that because I think I do provide care here as well. But, and within the setting here, . . . how far should you go with these people? And how much should you kind of pamper them. How often should you fill their medications and at what point should you kind of try to get, encourage them to do for themselves. And a little bit of the frustration also, and a really common issue both in the clinic and really in medicine in general is, you know, you're there, you're providing these medications, you're giving people advice, you know, you're telling them really the best thing you can do for your blood pressure is to stop smoking and change your diet a little bit; Do some exercise, walk, 15 minutes a day. Things that don't seem like that big of a request that would help them so much, and they're really very noncompliant, and that is very frustrating. . . .

And as far as abroad, the frustration there is you know that you are making such a small difference and you go there for four or five days and do clinic and give them medicines, and you don't, there's a language barrier and there's, you know they can't read or write, and you can't necessarily give them instruction, and you don't know that the things that you are telling them that will help them—and they're coming to you for help—you don't know if those are ever going to be carried out, and you don't know if they really understood what you were saying. . . . And if they do and everything goes exactly as planned, you still don't know and have a real good grasp of, you know, how big a difference are you making, because you've only addressing minor problems or simple things, and only for a little while, and their problems are really of a larger nature—of sanitation and those kinds of things that are really ongoing. And so those are the things that you face, but, and sometimes it's hard not to be discouraged, but for the most part it's very encouraging.

Several important themes regarding the effectiveness of medical philanthropy are touched on in this statement. The problem of non-compliance has already been mentioned in different contexts. Here it is seen in two dimensions, one of simple failure to do what is required for better health, the other of failing to understand (due to language and possibly cultural barriers) what one is being asked to do, e.g., in the taking of medicines.
Another theme is the lack of on-going relationships, and the attendant problem for the physician of not knowing whether one is being effective even when compliance is not at issue. A third theme is that of the need for social or systemic change, implicit in the reference to sanitation. Yet a fourth theme is that of paternalism, which this medical student perceives primarily as a problem with respect to the difficulties of securing compliance, but which needs to be seen in a broader perspective as medically and morally problematic. Non-compliance is not simply a problem; it is a symptom of what is deficient in a social or cultural context characterized by paternalistically structured health care delivery practices. This excerpt focuses on some unfortunate features in paternalistic relationships between patients and physicians, in particular, the lack of a sense of partnership and shared responsibility. The earlier excerpt from the physician who emphasized the need to work within indigenous social and cultural systems focuses on some of the unfortunate features of paternalistic first-world style health care delivery in third-world settings, especially the failure to establish programs that will be locally supported and sustained.

Although this is not the place to engage in extended comment on the problems with paternalism, clearly this can be an acute moral issue especially in contexts where medical services are being provided freely or for less than actual cost. In the interpersonal relationships between doctor and patient, paternalism tends to valorize many of the inequalities of our human estate. It fails to engender a sense of individual resources and strength. It may challenge the patient’s sense of dignity or self-worth. Over time it tends to erode the patient’s capacity to accept ownership and responsibility for health care. In intercultural and inter-societal relationships, paternalistic approaches that assume a superiority of knowledge, technique, or organization may undermine indigenous cultural patterns and practices that are integral to the healthy functioning of a society. Where existing cultural patterns and practices are unhealthy, as in the situation in Zaire described above, paternalistic medical practice will simply prove ineffective. The lesion would seem to be that the most effective provision of medical services requires collaboration with the leadership of the “patient” population, utilizing and building on the indigenous cultural and social resources where appropriate, and seeking to transform the existing cultural and social systems or create new ones where necessary. As one physician observed regarding the people with whom he is preparing to work,

The solutions are to get people trained over there that can make this sustainable. . . . There are plenty of very intelligent people over there. There’s no lack of human capital. That’s the thing that they have huge resources of, and so we hope to try and set up . . . systems that are sustainable.

NEED FOR SYSTEMIC CHANGES

Of all the sorts of issues encountered in the course of their philanthropic medical work by those we interviewed, two were mentioned with greatest frequency. Broadly stated, the first of these was the need for basic systemic changes in health care delivery in the United States. Major facets of this issue were the unequal allocation or distribution of health care resources and the related problem of limited access to health care services by a significant portion of the population. The second most frequently mentioned issue is also a systemic one, but was not usually perceived in quite the same
terms. That is the great disparity between the health care resources available to inhabitants of the United States and to the inhabitants of underdeveloped or third-world regions. This latter issue was much more frequently mentioned by students than by physicians, doubtless because most of them had relatively recently come to a more personal and vivid realization of this disparity as a result of their experiences while engaging in overseas philanthropic medical activity.

Expressions of the need for systemic change ranged all the way from personal lament to a proposal for global redistribution of wealth. As one pediatrician put it,

I can see things so clearly, how they should be, but there’s so many obstacles in the way. To me, I have no clue why we don’t have health insurance for all children. I do not see why. That doesn’t make sense, it makes so much sense to me. But there are so many political obstacles and economic obstacles and infrastructure obstacles, and just getting things done.

[Another pediatrician, whose own work environment is very satisfying, expressed frustration both with medical colleagues and with the current distribution of health care resources:]

[One of the issues, I see, is that this is a strong motivator, and I can see that this is part of our responsibility as a physician, to be engaged in extracurricular things, besides just in the office making money, and it bothers me when a large percent of the physicians, my colleagues, don’t share that. ... There’s so many doctors that aren’t happy practicing medicine right now, and I think it’s because they’re financially driven, not driven by other things. And I think if people could recognize the tremendous personal rewards you get from looking at things in a different way that their satisfaction with their job would be a lot higher. So that’s one thing that I’ve kind of gleaned from this. ... I think some of the ideas that I’ve grown older, because of my frustrations with basically the importance that people in politics have toward the health care of our children, so, you know, they speak like they want to, ... provide this care and coverage, but, I mean, you’ve got to figure out a way to do it, and it’s, they’re not doing it. ... I think that what I also find frustrating is that the people who decide where the money goes aren’t necessarily the people who should be deciding that, because I think if you had a system that was run, well there probably is plenty of money to provide a good level of care that needs to be provided. It’s just not going ... to the right places. ... We need to think, not of the box in terms of how we can provide affordable minimal preventive health care that’s shared by providers and patients.]

The current failings in the U.S. health care delivery system are so a significant degree perceived to be a problem of how we allocate our resources. “It’s how we spend our money,” said one physician. “I’m not sure that we need the next best version of an MRI, which costs five million dollars, when there’s so many kids that just need immunizations.” But, as some other physicians indicated, it is not just a question of how the money is spent, but of who makes the decisions, and how those decisions are made. “I never question that I should be doing what I’m doing, but I question how the overall structure is done,” said another physician. “So, just issues of, you know, is the energy and money and effort that goes into some things the right place or the right way to do things?” Yet another physician provided the following brief analysis of the nature of the problem:

The safety net is frayed, and unfortunately the systemic movement in the country is that the rich are getting richer and the poor are getting poorer, and I really feel like health care and education are basic parts of the infrastructure, like bridges and police.
And health care is in crisis, and as long as people are being thrown into bankruptcy by their medical bills and are dying young and being crippled by lack of medical care and we have a medical system which stacks up extremely poorly against the other nations in the world by objective standards, that really the issue is to try to find any, by whatever means, to try to develop, build consensus, build support for systemic changes.

Quite a number of physicians seem to regard our current health care delivery system as broken. Some also see current features of that system as obstacles to change and improvement. In the following comment, the reference is to the clinic where the physician is working:

The system conspires in some way against doing this kind of thing. You have to work with it. We have had a few volunteer doctors who would have liked to donate their time here who were unable to because of lack of malpractice coverage, and that is more or less a requirement in our modern world, structurally as well as financially. So that makes it one of those unfortunate things where even with a willing provider who’s willing to work on the basis of trust in a volunteer kind of thing, you’re left without that.

The medical students in our study who noted the shortcomings of the U.S. health care delivery system tended to focus on the general lack of access to health care services among the patient population they encountered in their volunteer medical settings. One student expressed concern that there might not be enough physicians to provide volunteer services in the future to meet the health care needs of the uninsured. More typical was the response of the student who reported that experience with medically underserved populations “really kind of made more clear to me the need for some sort of reforms in health care and making sure that more people can get a basic level of care in this country.” Perhaps the most poignant response to the current health care situation in the U.S. came from an undergraduate student with significant third-world medical volunteer experience. This student commented:

As a pre-med student I’m seriously questioning medical practices in the U.S. I think they’re very wasteful, and it’s made me question the whole institution of hospitals and medicine and health care in the U.S. It’s actually sort of destabilized me from wanting to practice medicine in the U.S. I think, easily, I can see myself being a doctor in another country, but I don’t know if I can in the U.S., just because I want to focus more on the patient, and the rout that medicine is following right now is focusing more on politics and insurance and law suits, and I never really realized that as much until I went on this trip. It hasn’t really affected political beliefs except that, I mean, I was aware the communities like this existed, but it never really hit home until I experienced it.

In part, this student’s feeling derives from a particularly meaningful overseas experience, but this response also articulates a critique that was partially echoed in the comments of other students we interviewed. Pre-medical and medical students with philanthropic motivations tend to be oriented toward helping people. The current bureaucratic jumble that characterizes the U.S. health care system is seen as more of an obstacle than a benefit or protection. The immediacy of patient care attracts these students. Many of them are filled with youthful idealism. But they are also bright enough and self-aware enough to recognize that the way medicine is structured and practiced in the U.S. today leaves much to be desired by them. It would not be surprising if two or three of them choose to spend the bulk of their careers practicing medicine outside the United States.

The other most frequently mentioned issue, the great disparities between medical resources in the U.S. and in third-world settings, came up far more often with the
students than with the physician. Again, the reason for this is doubtless that many of the students had recently had third-world experiences, some for the first time, and these experiences had made existentially real the disparities of which almost all of us are cognizant. Reflecting on a brief medical mission trip to Guatemala, one medical student commented,

"[I] always makes me think of why, why isn’t the Guatemalan government doing more for their own people? And then it always makes me think, will, why do those who are richer have more, why don’t they do more, and, yeah, I don’t know. I don’t have any well-formed ideas or questions in my mind... but I’ve always raised questions about the way things work in the world and why they work that way and what my role is.

In a similar vein, another medical student reflected:

"When you’re confronted with such a different culture and such a different way of life, you come about with the, why was I born when I am? Why am I doing this? You know. And at first I felt a little guilty when I came back, and enjoying what I have, because... talk about excess! Many people wouldn’t think of it as excess, but then it’s all relative. And so it took me a while to kind of come to terms with that, and it’s not a bad thing to be as blessed. However, if you are so, as I said before, I do think it’s in part almost your obligation to help those who aren’t as blessed, because you’ve been in such a good position and you have it to spare and you can help better a life.

A third medical student spoke more specifically of the differences between the United States and, in this case, Kenya:

"I think the Kenya experience in particular... really kind of heightened my awareness of the lack of resources in third world countries. I mean, I had known that obviously, but when you go and work in the hospitals there and see what facilities they have... and all that they don’t have and how they make do with what they have, it’s really an eye-opener and it really kind of demonstrates the need for resources there, and not only in terms of, like, medical equipment, but also the need for doctors and nurses and everyone else involved in medical care. So for me, I mean, it kind of raised the awareness... When I came back to the United States and I see all that we have here and people still complain about it and people still... they’re not necessarily grateful for everything that they have here, and that was kind of a huge thing that was raised for me. And you know, an issue that I really want, it really makes me want to go back and help people in third world countries. I can’t wait to go back to Africa and to go back to Kenya. I absolutely loved it there, and it makes you want to help those people even more because they are so grateful for any little amount that you give them.

The encounters of these three students with disparities in the human estate occasioned various different morally-tinged responses: a sense of unfairness with respect to such disparities; blame of a government that fails to provide for its citizens; the sense of obligation incumbent on the rich to help the poor, and blame of the rich for failing to do so; judgment or a rich society for its failures to appreciate its blessings; admiration for a poor but grateful people who carry on with dignity in spite of limited resources. None of these responses are very politically informed. However, the experiences that give rise to such moral sentiments may also help occasion some awakening of political consciousness.

For example, another medical student gave this response to the question about issues raised in the course of overseas medically-related philanthropy:

"I guess, politically, I don’t think that I’ve ever felt more frustrated with our own American government. And our, the way that we create policy, and the way that we have a tendency to look only at how things affect us, even though we know that by creating policy it affects the rest of the world. We’re not necessarily concerned about that when we’re making decisions here and that can be really frustrating."
As told to give an example, this student continued:

[One of the things that, when I was in Kenya, that the Kenyans would get so frustrated with— with our American government—is this new thing of the threat levels of travelling abroad. . . . Kenya was one of the places, when I went, that was under extreme caution to Americans that we shouldn’t be travelling there, and they wouldn’t say that you can’t travel there, but they would basically say that if you go there you’re throwing all caution to the wind and, you know, if you need our help, we tried to tell you not to go. . . . I don’t think that when we make those policies that necessarily they’re not informed as they should be, and number two, that they don’t take into consideration what kind of effect it has on those on the receiving end of that policy. And Kenya, you know, when 80% of their national income is based off of tourism, that has a big effect on their economy. And then you look at these patients that I’m treating that are HIV positive who have a profession or an income that is based on the economy that is based in tourism, you know, and now they can’t provide food to their family and they can’t get the medicines that they need to treat the HIV that they don’t have a choice in getting the virus just really frustrating, you know. And so I know that that’s taking it down, you know, taking it from the macro level to a microscopic level, but I mean, it does impact people. . . .

It is not clear whether the program that took this student to Kenya makes a concerted attempt to provide cultural and political background as part of the learning experience. It is clear that some such effort is made for Indian University pre-med students who participate in the Timmy Foundation programs in the Dominican Republic and/or Honduras. Two pre-med students who had been to the Dominican Republic both made reference to the political situation that exists with respect to the Haitian refugees who live and work just inside the Dominican border where the Timmy program sends them. One of these students, who demonstrated a fairly extensive knowledge of the conditions "on the ground," was highly critical of the government of the Dominican Republic for its exploitation of these Haitians as workers in the sugar cane fields. Both recognized that there are important political factors that help account for the impoverishment and health care needs of the people they are serving on their medical mission trips.

A third student, who has been active in leadership in the Timmy Foundation program, and who also happened to express strong criticism of U.S. government policy toward Haiti, nonetheless framed the issue of exposure to third-world settings, not in terms of political awareness as such, but precisely in terms of vocational exploration:

I think one of the main goals of the Timmy Foundation, and my goal with the Timmy Foundation, is to get college students out to do these things. . . . I think it’s really important for the Timmy Foundation to expose people who still have those sort of life decisions to make and career decisions to make, to see where they are needed. And I mean, granted they are definitely needed here in America, but especially physicians, to see that specialty may not be what you want to do, you may want to go into general medicine or. . . . I guess, specialize in infectious disease and come back to a third-world country and solve the problems, like people with TB in Haiti, you don’t see there. It’s a curable disease, but I mean, I don’t know what the percentage of people is that die there, but they’re all the time, and it’s spread all the time, and stuff like AIDS like, it’s not even, I mean, it’s a concern here, but not really, but just to expose people to that huge disparity between the rich and poor, the haves and have nots. I think it’s one of the big things that is being provided by the Timmy Foundation. . . .

For young physicians-in-training, motivated by the desire to help people and make a difference, exposure to third-world settings, where the needs are so obvious and the possibilities for making a difference seem unlimited, can be a life-changing, and career-determining, experience.
Let me conclude this section on disparities of wealth and the need for systemic changes by including the comments the physician who spoke most broadly of the need for redistribution of resources:

Sometimes I feel a little bit discouraged that we don’t make much headway in this country, with all the money that we have and all the expertise that we have. We’re so far behind what the ideal is, it’s just discouraging. And that goes for the entire world. It just boggles my mind that we are not able to take advantage of all our assets in ways to make this a better place to live.

As for what sorts of things would you want to see happen to make that better?” this physician continued:

Well, I think social justice based on redistribution of wealth. I feel very committed to that. You cannot expect people in poverty to ever pull themselves out of poverty without some help. And if you don’t have any institutions or any mechanism to help them, they’re never going to make it, and this is true in the entire world. We are not using our assets in ways to benefit the people of this world.

In American public life, reference is sometimes made to “the deserving poor,” as if to distinguish one subset of the poor from those who are not deserving. No one in our study referred to the poor, the indigent, the uninsured, or the underserved in such terms. That is, no one made any distinction between the “deserving” and the “undeserving.” Some of those we interviewed, in fact, were explicit in speaking of the circumstances of the poor as being, in effect, “through no fault of their own.” As mentioned earlier, there appeared to be no exceptions to the view that medical care should be provided to all who need it, regardless of their circumstances or ability to pay. For some, the existence of medically underserved populations represented an opportunity, and perhaps a moral obligation or demand, to engage in charitable medical work. For others, the existence of medically underserved populations also indicated the existence of a systemic problem that needs to be addressed and requires social, political, economic, or structural changes. The existence of large numbers of persons who lack adequate access to health care resources, whether at home or overseas, was in any event perceived as an issue—a moral issue, and for many a political issue as well—that calls for personal and professional response.

RELATIONAL ISSUES

A few physicians, when asked about the issues that had arisen in their work, mentioned relational issues of one kind or another. No single relational theme emerged as dominant, so I will simply report on some observations made by some of the physicians and one of the medical students we interviewed. One of those physicians stated that the most important requisite to being a physician is to become non-judgmental. Physicians are called upon to help and care for all kinds of people. This particular physician’s philanthropic activity has included work in Africa, where significant cultural differences were encountered. In this physician’s current context there are also persons of different races and religions, values, and life-styles.

It is evident from most of our interviews that engagement in charitable medical work is likely to place a physician in close contact with persons who come from very different backgrounds and very different life experiences. In other words, the population of those who have the greatest unmet medical needs, the poor and underserved.
also tend to differ from most physicians in other ways. This is obviously true of peoples in other parts of the world, but it is also likely to be true close to home. More than one physician who works with a primarily indigent patient population expressed the sense that there are neighbors or colleagues who wonder why they want to work with the patients they do. Why volunteer at the neighborhood clinic frequented by those who are on the margins of society? Why work at the hospital that serves a population of patients who are largely uninsured and belong to cultural or ethnic minorities? One medical student who plans to practice medicine overseas, perhaps in a mission hospital setting, said, "I have to explain myself a lot sometimes to people... when I explain to them what I want to do. I don't think it makes sense to a lot of people. . . ."

Another physician, whose volunteer work includes regular contact with an underserved population, a high proportion of whom have HIV/AIDS, expressed some of the personal challenge and opportunity that this work has afforded:

I sort of lived a pretty sheltered life. I mean, so I think that one thing is that it has opened me up to a large group of individuals that I would not otherwise have known. And along with that, exposed me to a lifestyle that is very, very different than mine, as well as maybe to some lifestyle choices that I would not make and that in my faith probably would not be accepted. And so then, you know, then, the question is, "Can you minister to people that you can't necessarily agree with their life choices?" And I think you can struggle with that, although my answer to that is, "That's not really for me to decide. I'm there to give them care and beyond that it's not for me to decide." But that is something that comes up, you know. People who know what I do will say, "Oh, how can you do that? Don't you have this or that? Or don't you have parents that use drugs? Don't you have this, don't you have that?" And I say, "Yes, but you know what? That has nothing to do with"—you know, we counsel them about getting their life together and offer them all the support, but try not to be judgmental, and that's, I think, that's a bonus. . . . It's a bonus to me because I think it's helped me as a person. I think it's made me more aware that not everybody's life looks like mine, and I think that has increased my tolerance for other people immensely. That I would not have gotten if I wasn't doing this kind of work. . . . And like I said, I know people I would never have known. The other thing is that I've been really fortunate to have met people who really have inspired me, both from the standpoint of some of the families that I take care of, and I see what their parents are capable of handling, and capable of living through—not just medically but in general—what their lives are like, and I'm inspired by that.

Dealing primarily with a patient population that is poor and medically underserved also introduces another dimension of difficulty. As another physician noted, "working with the poor is intrinsically a very, very difficult thing... [I] just... trying to figure out how to kind of deal with things on a little bit broader level than just taking care of people in the office space. And those people are very frustrating to deal with because they've got a lot of other priorities than their health. Just survival."

Most physicians actively engaged in philanthropic medical care probably have more different kinds of human relationship to negotiate than the typical physician. Those relationships include, first of all, the persons they care for who come from different patient populations than these physicians encounter in their ordinary employment. But those relationships also include other colleagues and staff in the various different cultural and institutional settings in which they may be doing their philanthropic work. As a fourth physician observed:

[You know, everything depends on people and
relationships. And the Achilles heels that I bring to the table, and the imperfections that others bring to the table, is sometimes a chemistry that can be really explosive. And it’s you fortunate that I think, in a sterile environment, you know, everyone—many—would often agree on kind of a path to take, and we’d be able to achieve it. But, you know, the reality is that’s not the world we live in. We live having to manage and work around human foibles. And so I think that has been a source of a tremendous frustration, that juxtaposed against just the enormous hope—that’s always there. But I guess if you didn’t have hope you wouldn’t have frustrations.

If there is a lesson to be drawn from these particular observations, perhaps it pertains to the need for pre-med and medical students to be provided as broad an educational and experiential background as possible. As the physician just cited went on to say, in support of the values of a liberal arts education, “I would rather have an English major and a philosophy major than a chemistry major coming into medical school.” And as so many of the interviewees in this study reported, engagement in service projects, church mission trips, and all kinds of other volunteer activities, whether medically related or not, can be a very broadening, eye-opening, and personally enriching experience.

THE VALUE OF GROUP PRACTICE

Although it was seldom mentioned specifically as an issue, the importance of group medical practice to engagement in philanthropic medical work was evident in a number of our physician interviews. “If you can establish yourself with a group of people that feel likewise,” reported one physician, “there’s a lot that you can do. It’s much more difficult, I think, if you’re by yourself.” In this case the physician was referring to various community involvements, education programs, and services provided or sponsored by a group medical practice. A very similar theme was sounded by another physician who is an active advocate for improving the quality of health care for the patient population served by the group practice to which this physician belongs, as well as strengthening the services and delivery systems for an even larger, underserved population in the community.

Several other physicians indicated at one point or another in the interview that being part of a group practice, especially a like-minded one, made all the difference in their capacity to engage in specific volunteer and philanthropic medical activities. For one, it made it possible to work half-time in order to provide leadership to a community agency serving the indigent. For another, it made it possible to cut back on hours in order to advocate for health care reform and take on community leadership in expanding and improving health care services to the underserved. For several others, it made periodic mission trips possible. For yet another, the contributions of other physicians as volunteers provided relief that made it possible to sustain a program of services to the uninsured.

For most of these physicians, group practice is a financial advantage if not necessity. It has become an important way to cope with the high overhead costs inherent in the current U.S. medical insurance system. As previously noted by one physician, a well-run group practice can make a physician inadvertently wealthy! However, it can also provide sufficient economic margin to enable physicians who are so inclined to take care of disproportionately large numbers of patients who lack adequate insurance or financial means to pay for the services they receive.
A well-run group practice can enable a physician to afford to work less than full-time in order to contribute his or her skills to other philanthropic endeavors. A group practice, even if not of great financial advantage, can provide a cohort of medical colleagues who can periodically cover for one another in order to enable those who wish to give of their time in volunteer medical work. Examples of each of these possibilities are to be found among the physicians we interviewed.

THE PERSONAL COSTS OF MEDICAL PHILANTHROPY

In our interviews we asked each subject about the personal costs and rewards of their philanthropic medical work. I have already reported on what most of them had to say about the rewards. As for the costs, the most frequently mentioned was time. For many, the cost in time seemed trivial: not playing golf, which was of little interest anyway; not watching TV in the evenings; not getting to sleep in on Saturday mornings; spending ten days overseas instead of at a summer home; devoting spring break to a medical mission trip; cutting into study time. For some, however, the issue of time was not so easily dismissed. It meant less time with family or close friends. It meant less personal time. Or it meant a significant change in work priorities.

Another cost was money. Again, for many this seemed a rather trivial cost. It might be the cost of travel or it might be the cost of monetary contributions to the organizations with which one is involved. However, for at least a few, the $1600-1500 spent on a plane ticket to Central America was not an insignificant cost. As one student indicated, it required considerable scrimping and saving, foregoing such things as movies and eating out. The larger cost in money, obviously, is the income foregone by those who choose to work in settings where their compensation is notably less than it could be elsewhere, and those who choose to provide their services to populations of disproportionately under-insured patients. That is surely the primary financial cost that is at stake in most decisions to engage in medically-related philanthropic activity. For one physician we interviewed, whose sense of calling led to the adoption of a special needs child, there have been major costs in both time and money, as well as in other opportunities foregone.

Besides time and money, several other costs were mentioned. One was the growing pains of working in a new and unfamiliar environment, with people and issues that have not been part of one's remunerated work. For some there were the discomforts of a third-world environment. One medical student reported, "Often I get sick when I'm out in the boondocks." A pre-med student who had been on one of the Timmy Foundation-sponsored trips, reported, "when I came back I was experiencing some kind of medical conditions of my own. . . . I don't even know what I had, but we all kind of had some kind of stomach problems and some rashes but, I mean, that was like the biggest downfall of the trip, and it was totally worth it." For some of those we interviewed, the rigors and simplicity of life in third-world settings are part of the challenge, for at least a few they seem to have their own positive attraction.
One physician who has worked in a third-world setting accompanied by family expressed a concern of a broader nature regarding the risks of such an environment: “What would happen if our kids got sick? If they were in an automobile accident? If we were subject to random violence?” Another said, “I worry a little bit because I can’t get as much health insurance as I want, or life insurance—working as much as I do overseas I can’t get it, literally can’t get it, without paying an exorbitant amount, so I don’t do that.” As these two comments indicate, philanthropic medical activity can impose costs on family other than simply the time that the physician-spouse and/or parent spends away from home. Yet another kind of cost is that of the demands placed on siblings and other family members if the home by an adopted, special-needs child.

Three of the medical students we interviewed indicated that the type of philanthropic medical work they envision as integral to their vocations may bear a special cost in terms of relations to persons close to them. One intimated that it might preclude marriage with a potential life-partner who is planning on a different sort of medical career. Another, who wanted to work overseas as soon as possible, and who has younger siblings and well as parents at home, reported, “for me the biggest sacrifice is probably going to be just not being around or so close to my family.” A third, who also plans to practice medicine overseas, clearly had to struggle with the fact that her parents have not been at all supportive of her vocational decision:

[If] I do pursue this philanthropic work as I currently intend to, it definitely comes at the cost of being separated from my family—you know, the people who I love more than anything—and that will definitely be hard. But, and furthermore, ... my parents want grandchildren so badly that they’re just desperate, and my mom is just convinced that I’m going to go over there and, you know, have grandbabies that she’s never going to see me get to raise ... so that’s a concern for them as well, and would definitely be a personal cost to me as well, because I know, I can’t say that that will or won’t happen, but if it would, how unfortunate would it be, you know, that my potential future children wouldn’t get to grow up around their grandparents.

Clearly, in some instances, the commitment to compose a life that involves significant engagement in philanthropic medical work can entail a profound alteration not only in one’s own life prospects but also in the most basic and important of human relationships, the relationships of marriage and family.

To conclude this section on the potential costs of participating in medical philanthropy, I want to report on the responses of one medical student who has spent time in a third-world setting and three of the pre-medical students, each of whose experiences include participation in Indiana University’s Timmy Foundation program in either Honduras or the Dominican Republic. What are the costs of such philanthropic activity? In their own words:

For one, going down to Honduras is a big culture shock, and it really humbles you, and your experience here in the United States just sort of makes you realize how great things are here, and how privileged you are. Well, every time you come back you feel like a total materialistic snob, because you walk around in these towns where people are living in houses made out of poured tin cans and they don’t have any running water and their kids have either pants or a shirt to wear, and you come back and your friends are talking about, you know, getting drunk in Florida or going to Mexico, and it makes you feel bad about yourself. And then it makes you angry at your friends, and so it is no one’s fault, because by luck we were born here and they were born there, and not everyone wants to
see sad things. And my sister, I don't know how to talk about some stuff with my sister. She just goes "shut up," and makes me feel bad. And so I get really frustrated. I guess, with the way I live, and I continue to live that way. Because you have to stop and you have to say, you just have to realize that I'm not going to walk around in rags because I feel bad that other people are doing it. I mean, that would sort of exclude me from my social circle, but so, I guess, when you come back you just feel bad and you start to question everything about yourself.

It has been a very frustrating experience for me coming back here, which I would have never expected. I mean, I think for all of the reasons that I have listed, after all of the issues that were raised for me, after having been involved in working in Orland, much of my experience here has been one big lesson in frustration—and not to say that there's not value in it, I mean, I think personally and professionally I've learned a lot in that frustration, and how do you deal with the dichotomy and the diametrically opposed resources and funding here versus those, so that has been frustrating but also very beneficial, I think, for me to be able to experience that. . . .

I think . . . the most I can see myself sacrificing in the future is a certain degree of comfort with the life I have here in the U.S. It's very comfortable. It's very comfortable to ignore the problems that you see as you go four miles south of Bloomington, as you go to very high poverty areas, or you go to Honolulu. If you don't seek it out, I think you very well can live your life without ever having to see that, or ever feeling you have an obligation to people. And so, I guess the cost would be sort of a comfort value. Does that make sense? A security, I think. But then, I mean, it goes hand in hand, too, and you can say that, like, well, I have security is knowing that I'm doing what I'm meant to do. So I think the benefits definitely far outweigh the cost.

In conducting many of the interviews for this study, and in reviewing all of the transcripts, I have been privy to some remarkable stories. Many of these stories are humbling. Some of them are truly inspiring. All of them attest that engagement in medically-related philanthropic work can profoundly influence the personal and professional lives of physicians and, especially, physicians-in-training. For most of the physicians we interviewed, there is substantial overlap of the personal and the professional. For some, the personal and the professional are virtually indistinguishable: their life is their work, and their work is their life. In any case, it appears that personal experience has played an incalculable role in the professional choices and aspirations of those we interviewed.

In that light, I wish to conclude this review of our research in moral issues and motivations in medical philanthropy with excerpts from the remarks of one of the medical students we interviewed for whom that is most obviously the case. The question asked by the interviewer was, "Tell me how has your thinking about medical work changed, if it has, over the time in which you've been engaged in it?"

This student's answer:

. . . I wish that people entering the field of medicine were asked to do, to participate in it, because I never really thought that it would have had this much impact on my life. I never expected coming into it that it would truly, truly be a life-changing event for me. I wonder how many people have not experienced that only because they haven't taken the time to experience it once. You know, I wonder how many more people would be working philanthropically had they tried it. So I don't know, and I don't necessarily think—I mean you can't certainly force people to do philanthropic work—but I think, if out, if even cur training were set up differently such that there were more opportunities so that physicians didn't feel like
they were so tied to their work here that they couldn’t get a break, or couldn’t get away, or couldn’t afford to be away from their practice and their patients for a little bit of time, that maybe we would have more people, you know. Because I know that there are a lot of people that say, “I would love to go, but how can I? How can I physically make this possible?” You know, so maybe if our system as a whole were changed, and specifically if our educational system were changed at a time in our lives where, yes, we are busy, yes, there’s a lot to learn, but there are no true patient obligations ongoing for students and residents. I mean, I think JTTU does a great job in allowing their residential students to go, but in other educational settings, if we provided more of an opportunity to make this a possibility, how different would the world be if there were more people involved?

In this study we had the privilege of speaking with a number of people who are helping to make the world a different, and better place. How different, and how better, might it be if even more people were involved?
Appendix A

A variety of approaches was taken to identify and recruit suitable candidates for the study, with different strategies employed with respect to each cohort group, the physicians, the medical students, and the pre-medical students. To identify and recruit physicians, we solicited the help of three outside individuals well acquainted with their local medical communities, a former hospital administrator, a hospital chaplain, and a physician who works in a teaching hospital and teaches medical ethics. In the course of contacting individuals suggested by them, we were sometimes provided with concuring recommendations by other physicians, and occasionally had someone not on our list recommended to us. One unsolicited recommendation came serendipitously from a third party. Contacts with over 25 physicians were necessary in order to secure positive responses and actual interviews with 15. Most of these were conducted in person, but a few were over the phone.

Recruitment of pre-medical students was relatively easier. The names of approximately a dozen prospective interview candidates were initially provided to us by the Director of the Health Professions Prelaw Information Center (HPPLC), a component of the University Division academic advising services at Indiana University Bloomington. One additional name was later added, as the initial list yielded only nine interviews. All of the interviews with pre-medical students took place in person at the Poynter Center.

There was considerable difficulty in securing the names of prospective participants currently in medical school. Repeated efforts to enlist the assistance of the Office of Medical Service-Learning of the Indiana University School of Medicine failed. Fortunately, the names of a few former pre-med students now in medical school were provided us by HPPLC. The names of about half of those who actually participated in the study were eventually successfully solicited from a contact in medical education in Indianapolis. In addition, a fortuitous meeting with a physician from the University of Texas Medical Branch in Galveston, Texas, led to an offer on his part to help recruit students from his program, two of whom were needed to round out the complement of ten medical students to be interviewed for the study. All but two of the interviews with medical students took place by phone.

Four persons conducted all of the interviews. Two research assistants, Melissa Seymour and James Bourke, interviewed eight of the pre-med students. The Principal Investigator who directed the study, Richard Miller, interviewed four of the physicians. The remainder of the interviews were conducted by the Research Associate, Byron Hanger.

Each interview was structured by the same set of 19 questions (Appendix B). These questions were prepared with physicians in mind. Interviewers exercised some freedom in pursuing other questions, and sometimes all of the questions did not get asked, depending on the course of the interview itself. In the case of medical and pre-medical students, interviewers made ad hoc modifications to the questions when and
where appropriate to the interview subject and his/her status as a student rather than an already practicing physician. The interviews took an average of about 40 minutes, with the shortest being 22 minutes and the longest taking almost 1½ hours.

With one exception, all of the interviews were recorded in their entirety. These recordings were transcribed by a local transcription service. The transcriptions were initially checked for basic accuracy, and re-checked where specific passages have been quoted. A careful attempt has been made to disclose interesting and relevant information about interviewees whose views are cited, or whose statements are quoted, while preserving the anonymity of every participant.
Appendix B

INTERVIEW QUESTIONS
Moral Issues and Motivations in Medical Philanthropy

BIOGRAPHICAL BACKGROUND:

Name:
Address:
Phone:
Email:
Preferred means of contact:
Current position:
Education:
Places and dates of medical training:

EXPLORATORY QUESTIONS:

1. What influences, factors, and/or events led you to enter the field of medicine as a profession?

2. How did you come to your current position? Include any significant previous educational and work experiences that prepared or inclined you to decide to be where you are now.

3. Describe the nature of the philanthropic medical work you are now doing.

4. How much of a time commitment does this require?

5. Why are you doing this? What animates or motivates you to be involved in this way?

6. When did you first imagine or consider doing philanthropic medical work? When did you first engage in it?

7. What do you aspire to accomplish in this work?

8. How does this philanthropic work relate to your sense of professional identity? For example,
does it compensate for something that is lacking in your current position? Or is it a natural outgrowth of that position? Is it integral to your professional identity? Or do you do it for reasons that have little to do with your professional identity as such?

9. How does your philanthropic medical work fit into your overall life and work? Does it compete for time? Does it contribute to, or detract from, your ability to perform the work you are required to do in your current position? What effect does it have on your relations with your significant others? With the community in which you live? With other members of your profession?

10. What are the personal costs and rewards you experience in doing such work?

11. Would you describe your philanthropic motivations as religious? moral? political? If so, in what way(s)? If not, how would you describe these motivations?

12. Apart from the sheer demands of your philanthropic work in terms of energy and time, what issues has this work raised for you professionally? religiously? morally? politically?

13. In what ways, if any, have you found your aspirations frustrated as you have engaged in philanthropic medical work?

14. What solutions, if any, can you envision with respect to the issues and frustrations with which you have been confronted in your philanthropic work?

15. How has your thinking about philanthropic medical work changed over the time in which you have been engaged in it?

16. What sorts of philanthropic medical work, if any, do you envision yourself doing in the future, and why?

17. What sorts of philanthropic medical work, if any, do you intend to avoid in the future, and why?

18. How do you regard your charitable medical activities in relation to the expectations of your profession? Are such activities encouraged or discouraged, seen as exceptional or taken for granted, among other members of your profession?

19. What do you think we should know about the moral issues and motivations in medical philanthropy that I have not already asked you about?
Appendix C

INFORMATION

The method of the study involves structured interviews of approximately one hour with pre-med students, medical students, and physicians who have been and/or currently are engaged in some form of philanthropic medical work.

The active period of the study is expected to extend from October 2004 through June 2005.

There will be 25 subjects in the study, ten pre-medical students, ten medical students, and fifteen physicians.

All interviews will be recorded and later transcribed for analysis and reporting.

The study involves no use of deception.

RISKS

No significant risks are anticipated in this study.

BENEFITS

No direct or tangible benefits are offered to participating subjects. It is anticipated, however, that the project will contribute to the Center on Philanthropy's Research Priority Areas of the sources and motivations of philanthropic resources of time and, in this case, medical expertise, and thereby promote effective encouragement of others to participate in medical philanthropy. We also seek to understand what makes charity medical care a positive experience in order to encourage continued participation by those who are engaged in this work.

CONFIDENTIALITY

All interviews will be recorded and transcribed. Interviewees will be identified by name and by cohort (pre-med student, medical student, or physician) on the transcripts. Recordings will be kept until July 1, 2005, and then destroyed. Transcripts will become part of the archives of the Poynter Center, reserved exclusively for use by the Center, including possible use in connection with subsequent grant to continue research in extension of this project.
Reports of research will be written in both aggregate and individual terms, but without personal identifiers. All final and publishable reports for this project and any future Poynter Center studies utilizing the research of this project will exclude names and other obviously identifying information.

**CONTACT**

If you have questions at any time about the study or the procedures, you may contact the researcher, Richard B. Miller, at The Poynter Center, 618 E. Third Street, Bloomington, IN 47405; 812 855-0281; miller3@indiana.edu.

If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact the office for the Indiana University Bloomington Human Subjects Committee, Carmichael Center L03, 503 E. Kirkwood Ave., Bloomington, IN 47408, 812/855-3067, by e-mail at iub_hsc@indiana.edu.

**PARTICIPATION**

Your participation in this study is voluntary; you may refuse to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

**CONSENT**

I have read this form and received a copy of it. I have had all my questions answered to my satisfaction. I agree to take part in this study.

Subject's signature ________________________________ Date ________________

Witness signature ________________________________ Date ________________

(required if form is read to subject)

Consent form date: September 16, 2004
Revised: January 14, 2005